gestation. The 3040 g female infant presented with respiratory distress. A bilateral pleural effusion rapidly re-occurred necessitating total parenteral nutrition and repeated thoracocentesis during the first 2 weeks. On day 18, a chest tube was inserted in the left side. On day 35, the accumulated volume extracted reached 1100 ml and intrapleural instillation of 5 ml povidone-iodine (Betadine Dermique 10%) was performed. The pleural effusion resolved within 24 h, but respiratory status worsened 12 h after povidone-iodine infusion with hypotension, metabolic acidosis (pH 7.1; HCO₃ 12 mmol/l), and acute renal failure. Haemodynamic instability, acidosis, and respiratory status improved within 48 h. Anuria persisted and the patient required peritoneal dialysis for 15 days. Severe chronic renal failure (creatinine clearance 20 ml/min/1.73 m²) was present 6 months later, although the patient had had normal renal function before treatment.

Because of the persistent pleural effusion, we decided on an intrapleural instillation of povidone-iodine as reported previously.¹ The pleural effusion resolved but severe adverse reactions occurred within 12 h after povidone-iodine instillation. Metabolic acidosis, hypotension, and respiratory and renal failure have been previously observed in adult and paediatric patients who had received high doses of povidone-iodine topically applied to burns covering ≥20% of the body surface area or after continuous mediastinal irrigation.^{2,3} Acute renal insufficiency is a well known effect of povidone-iodine intoxication, particularly in patients with chronic renal failure.

One of the four infants reported by Brissaud *et al* died from end stage renal failure after three intrapleural povidone-iodine instillations.¹ The autopsy showed diffuse congenital lymphangiectasis. We hypothesised that such an abnormality may have favoured massive iodine absorption and intoxication in the case reported by Brissaud *et al* as well as in our patient.

We wish to warn of the risk of severe adverse effects after povidone-iodine intrapleural injection, particularly when pulmonary lymphangiectasis is suspected. Recently, somatostatin was successfully used for post-operative chylothorax in neonates when conservative treatment failed.^{4,5} A large prospective study needs to establish the safety and efficiency of somatostatin in the treatment of persistent chylothorax.

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The importance of colour

Some months ago a lady had an uneventful first pregnancy and delivered her baby vaginally near term. Both mother and baby were transferred to the postnatal ward shortly after the birth. As the hospital is committed to the Baby Friendly Initiative, she was encouraged to establish breast feeding and to have skin to skin contact with her baby while lying on her bed. As she was extremely tired after a long labour with a spinal anaesthetic, she dozed off and her baby rolled off the bed on to the floor. Mum called the midwife to check the infant over, and she subsequently brought with her the baby's routine set of yellow baby notes so she could document what had happened. The baby was fortunately not injured, and there was no apparent bruising. However, as a precaution a skull x ray examination was performed. This showed a linear mark, which was felt to be vascular and not a fracture. Mum was made aware of this, but remained very anxious about her baby. Both mother and infant progressed well and were discharged home.

Some weeks later they attended for a follow up appointment. The infant was thriving and making good developmental progress, and, as there were no other concerns, the infant was to be discharged from the clinic. Just before leaving, Mum asked for a photocopy of the notes. We were a little surprised at this request as there had not been any adverse outcome, and no concerns had been expressed over the baby's inpatient care. We therefore enquired why she had requested them. She explained that, when the midwife had come to see her baby that she had brought a yellow set of notes. She had seen her own maternity hospital and hand held notes, which had always been white. She had not appreciated that all newborn infants had a yellow set of notes capturing basic demographic and birth related details. She had interpreted the use of the yellow set of notes as representing something very negative. Was she being marked out because her baby had rolled out of the bed? What had been written about her in the yellow notes? Would these yellow notes be on her file permanently? We explained that all newborn infants had a yellow set of notes and showed her what was written and she was reassured. Mum left the clinic (without the photocopy of her notes) feeling happier.

Intrigued by the consultation, we wondered how often the use of a simple colour

within medical notes leads to the unexpected generation of anxiety, whether this had been observed by other paediatricians or midwives, and how we might recognise this earlier and provide reassurance.

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RSV and bronchiolitis

In the study by Bala and colleagues,¹ it seems that interpretations on cost effectiveness of palivizumab are made based on the number of admissions for bronchiolitis alone.

We conducted an epidemiological study to determine the importance of respiratory syncytial virus (RSV) in the region on 412 consecutive 1 month to 2 year old children admitted to a tertiary hospital in Kelantan, Malaysia, because of lower respiratory tract infections (1 January to 31 December 2001). We based our diagnosis of RSV on viral antigen detection in nasopharyngeal aspirates from the children.

We found that in our setting only 26.2% of patients with bronchiolitis were RSV positive. On the other hand, among the patients diagnosed to have pneumonia, 21% were RSV positive. We also identified a clear seasonal trend, with a strong peak in the rainy season and RSV infection being extremely rare in the dry season.

Our data caution against just taking clinical bronchiolitis as a sole indicator of RSV infection. On one hand there may be an overestimation of RSV infection since by far not all bronchiolitis is due to RSV. On the other hand the more severe or complicated RSV infections may be missed, underestimating the burden of RSV for a given population.

Calculations on the true burden of RSV should also take into consideration the pneumonia cases resulting from or complicating RSV infection and also the potential long term effects of RSV infections.²

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Postnatal ultrasound: a minimum requirement for moderate antenatal renal pelvic dilatation

I read with interest the report by Plant *et al*,¹ in which it is suggested that children with an antenatal renal pelvic diameter of 5–15 mm do not require postnatal investigations or treatment, as their rate of renal scarring with