



Decline of hospital admissions for MMR vaccinations in children with egg allergy

P Govindaraj, M Alfaham, C Davies and D Tuthill

Arch. Dis. Child. 2009;94;914-915
doi:10.1136/adc.2009.166371

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LETTERS

An audit of urine culture results in well infants attending a prolonged jaundice clinic

The National Institute for Health and Clinical Excellence, UK guidelines¹ suggest routine urine culture for infants with prolonged jaundice. It is time-consuming, costly, and anecdotally, urine cultures were rarely positive in our experience. We wanted to investigate the need for this practice in well babies with prolonged jaundice. We have a nurse-led prolonged jaundice clinic in our hospital, where babies referred from the community with prolonged jaundice are reviewed. As part of the assessment, which involves detailed history and examination, they all have urine culture. If urine culture is positive, they are managed as per local policy for urinary tract infection (UTI). We undertook a retrospective case note and microbiology database review of urine culture results for the well infants attending this prolonged jaundice clinic from September 2002 to April 2007 (4 years and 7 months). Possible UTI was described as the presence of white cells and/or growth $>10 \times 10^6/l$ (mixed or single organism). Infants with possible UTI were grouped as Group A and Group B based on the presence or absence of white cells in urine. Those infants with possible UTI were recalled and recultured and if they met the criteria for UTI they were treated. All 256 infants who attended the clinic had a urine culture. Five point five per cent (14/256) of infants met the criteria for possible UTI. On recall and reculture only 0.8% (2/256) of infants met the criteria for UTI and were treated as such. Of these two infants, one had white cells present in the initial urine and was found to have grade III reflux at follow-up. The other infant, who had no white cells in the initial urine, had normal investigations at follow-up. Table 1 illustrates the results.

In conclusion, urine culture was rarely positive in well infants attending the prolonged jaundice clinic. We recommend that as UTI was rare in babies with prolonged jaundice, urine dipstick might prove to be a more beneficial and cost-effective practice as a screening tool in well infants with prolonged jaundice instead of the current more costly and time-consuming practice of urine culture for all such infants. Further studies are needed to demonstrate the efficacy and safety of such an approach.

V Satwik, D Booth

Neonatal Intensive Care, Norfolk and Norwich University Hospital, Norwich, UK

Correspondence to: Vikas Satwik, 18 Grange Court, Chelmsford CM2 9FA, UK; drsawtik@yahoo.com

Competing interests: None.

Provenance and peer review: Not commissioned; externally peer reviewed.

Accepted 1 July 2009

Arch Dis Child 2009;94:914. doi:10.1136/adc.2009.157396

Table 1 Urine culture results (initial and recall) (n = 14)

Group	Possible UTI (n = 14)	Growth $>10 \times 10^6/l$	Treated as UTI, after recall and reculture
Group A: white cells and growth (single organism or mixed)	5/14	3/5	1/5
Group B: pure (single) organism growth in the absence of white cells	9/14	2/9	1/9

UTI, urinary tract infection.

REFERENCE

1. NICE. NICE guideline on urinary tract infection in children, August 2007. <http://www.nice.org.uk/Guidance/CG54/Guidance/pdf/English> (accessed 27 Jul 2009).

Decline of hospital admissions for MMR vaccinations in children with egg allergy

Concerns have previously existed about the potential for measles, mumps and rubella (MMR) vaccination to cause an adverse allergic reaction in children who have egg allergy. Concern about possible allergic reactions has led to many children with egg allergy being referred for vaccination in hospital. Common practice has thus been to administer the MMR vaccine to such patients in hospital settings. Aickin *et al*'s article in the BMJ suggested that measles immunisation was safe to give to children with egg allergy, but should be performed in a setting where any adverse reactions could be dealt with appropriately.¹ The safety of MMR in children with egg allergy was further demonstrated in 2000.² Khakoo *et al* stated that the majority of life-threatening (cardiorespiratory) allergic reactions to MMR vaccine had been reported in children who were not allergic to eggs, and were more likely to be explained by reactions to the gelatine or neomycin contained in the vaccine. MMR vaccine is as safe as any other vaccine, and an allergy to eggs should not delay the administration of measles vaccination.²

Thus in 2007, the British Society of Allergy and Clinical Immunology (BSACI) issued specific recommendations regarding administration of MMR vaccine in egg allergy. It stated that administration of MMR vaccine to children with egg allergy has an excellent safety record and may be administered to all egg-allergic children as a

routine procedure in primary care. The MMR vaccine is grown on cultured-embryo chick fibroblast and is therefore generally free of hen's egg protein. When traces of hen's egg protein are found, the protein is highly processed and the concentrations are too low to represent a risk.

Previously in our department, two individual consultants from six who would receive general paediatric referrals, wrote to general practitioners (GPs) following the publication of the BMJ article, stating that MMR vaccination was unlikely to produce anaphylaxis in egg-allergic children.² However, this appeared to have little effect on reducing the numbers of children receiving MMR vaccination in hospital. Following the BSACI guidelines (2007), the outpatient sister who received many referrals from GPs and some paediatricians, was empowered to send a standard letter including this advice straight back to the referrer to defer patients from unnecessary day case admissions. We audited the effect of this practical change on the number of admissions for MMR vaccinations performed in our hospital, their indication and associated complication from 2005 to 2008 (4 years).

The results showed a fall in the number of MMR vaccines administered in the last 2 years (table 1). There have been no immediate complications or any adverse reactions noted in the patients who received MMR vaccination in hospital since 2005. The patients who received MMR vaccinations in hospital since 2007 were mainly those who had a severe previous reaction or where the parents were extremely anxious and had requested hospital vaccination.

In summary, we feel primary care providers should be reassured in administering MMR vaccination in primary care, and the BSACI and BMJ recommendations help paediatricians in conveying this point.

P Govindaraj, M Alfaham, C Davies, D Tuthill

Department of Paediatrics, University Hospital of Wales, Cardiff, UK

Correspondence to: P R Govindaraj, Department of Paediatrics, UHW, Cardiff CF14 4XW, UK; Julu31@yahoo.co.uk

Competing interests: None.

Provenance and peer review: Not commissioned; not externally peer reviewed.

Accepted 8 June 2009

Arch Dis Child 2009;94:914–915.
doi:10.1136/adc.2009.166371

Table 1 Annual hospital admissions for measles, mumps and rubella (MMR) vaccination

Year	MMR vaccines administered in hospital
2005	17
2006	17
2007	7
2008	4

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2. Khakoo GA, Lack G. Recommendations for using MMR vaccine in egg allergy children. *BMJ* 2000;**320**:929–32.

George Frederic Still

We read with interest the “perspectives” authored by Brandon *et al* (*Arch Dis Child* 2008;**94**:173–7). It is a timely reminder of the debt of gratitude that we owe to the Platt report which revolutionised the care of children in hospital in the UK when it was published in 1959. The transcript of Brandon’s talk to the National Association for the Welfare of Children in Hospital in 1986, describes the road to progress in recognising that hospitalisation of children could be harmful and that having mothers staying with them was beneficial. There was indeed antagonism between the two pioneers, Spence and Robertson, one coming from a paediatric background and the other from psychology. In her commentary, Mary Lindsay, a child psychiatrist, gives an interesting explanation that one of the reasons for the differences of opinion between Robertson and Spence was that they were coming from opposite poles. Spence wanted mothers to come into hospital for the mother’s benefit and he would select which ones should be admitted. Robertson, on the other hand, was clear that it was for the child’s benefit. It is true that there was considerable antagonism generally between physicians and psychiatrists/psychologists and this may have played some part.

However, we would take issue with Lindsay’s statement “Spence idealised mothers (he adored his own mother and never married)”. Spence was married and had four children of his own. We suspect Lindsay is confusing him with that other great paediatric pioneer Still who never married and was said to have liked only two women, his own mother and the late Queen Elizabeth the Queen mother.

Finally, we cannot let the statement that Spence was a snob go unchallenged. One of us worked with him and the other saw him as a patient at the age of 4 with a stutter. Between us, we have talked to many people who knew this great man and the one description which does not fit him is snob.

Spence would be amused to see that the antagonism of psychiatrists for paediatricians lives on.

A Craft, H Jackson

Royal Victoria Infirmary, Newcastle Upon Tyne, UK

Correspondence to: Alan Craft, Royal Victoria Infirmary, Newcastle Upon Tyne NE1 4LP, UK; a.w.craft@ncl.ac.uk

Competing interests: None declared.

Provenance and peer review: Not commissioned; not externally peer reviewed.

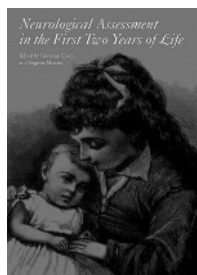
Accepted 5 March 2009

Arch Dis Child 2009;**94**:915. doi:10.1136/adc.2009.161224

BOOK REVIEW

Neurological assessment in the first two years of life

Edited by Giovanni Cioni, Eugenio Mercuri. Published by Mac Keith Press, London, 2008, pp 256, £80 (hard cover). ISBN: 978-1-898683-54-4



This book was published in 2008 by the Mac Keith Press as part of the Clinics in Developmental Medicine series and edited by Giovanni Cioni from Pisa and Eugenio Mercuri from London. What did I hope to find in a book on this subject? I hoped it would contain something for the busy clinician assessing a child in clinic who needs a guide to clinical neurological assessment. I also hoped there would be information on the latest investigations in infants with untoward early neurological events and that when the clinician was faced with a parent on the neonatal unit, he or she would be better informed to predict the likelihood and extent of neurological disability. This book realised some of these hopes rather well.

The book can be roughly divided into five parts. The initial chapters deal with the neurophysiological basis of development, which may be of interest to clinicians who feel they still have the remnants of the scientist within them. The second part deals with the neurological examination of the normal and the high risk infant with and without neurological abnormalities and brain lesions. The recommended and alternative approaches to assessment are described. The third section describes investigations that help us diagnose and prognosticate outcome where there may have been an antenatal event or a neonatal insult. Here MRI and electrophysiology is dealt with. In the fourth part, there are chapters that focus on cognition, communication and the sensory modalities of vision and hearing. Finally, there is a description of long term outcome studies and rehabilitation.

I think the book will be of interest to the general paediatrician and the paediatrician with an interest in neurodisability. Neonatologists will also find the book useful as will paediatric neurologists. Some therapists who care for children with complex needs may wish to refer to certain chapters. The book is scientific in its outlook and is probably aimed at the expert rather than intended for casual reading. Paediatricians caring for sick newborns who have to share the news of abnormal neurology and abnormal brain scans in the neonatal period will find this book beneficial. The prediction of neurological outcome is always fraught with uncertainty and this book may help the clinician to explain to the parents the state of knowledge and research on the subject.

The book contains some very useful information about the assessment, investigation and management of infants with developmental abnormalities. There is a good list of references and there are contributions from established authorities in the field. I found the chapters on the neurological assessment of normal and abnormal infants very useful. Also, the current state of research and knowledge with respect to MRI scans and EEGs was valuable reading. The myriad of development assessment tools available is evident from the subsequent chapters, but busy clinicians can limit themselves to those they are familiar with.

The book could have used case illustrations a bit more to make the issues real for the reader. Certainly, those with a neurodisability caseload would have appreciated how the information presented relates to the children that they see in the child development centre. This volume will help us clinicians to continue to remain focussed on the idea that every newborn, infant or child we look after is an individual and not simply a statistic with a p value. It is challenging to bring research to the grass roots arena and even more difficult to bring a family perspective into what is essentially a scientific treatise. The book gets a bit heavy at times and prompts you to speak to the friendly neurologist down the road. This is no criticism but really a reflection of the illustrious nature of the author’s background. Some parts of the book are more suitably targeted at the neurologist than the paediatrician.

Provenance and peer review: Commissioned; not externally peer reviewed.

Arch Dis Child 2009;**94**:915. doi:10.1136/adc.2009.157768

S Suri

Rotherham NHS Foundation Trust, Moorgate Road, Rotherham S60 2UD, UK; sanjay.suri@rothgen.nhs.uk