



Did you know this medicine has peanut butter in it, doctor?

Viktoria Dixon, Shaymau Habeeb and Raman Lakshman

Arch. Dis. Child. 2007;92;654-
doi:10.1136/adc.2007.120949

Updated information and services can be found at:
<http://adc.bmj.com/cgi/content/full/92/7/654>

These include:

References

This article cites 2 articles, 1 of which can be accessed free at:
<http://adc.bmj.com/cgi/content/full/92/7/654#BIBL>

Rapid responses

You can respond to this article at:
<http://adc.bmj.com/cgi/eletter-submit/92/7/654>

Email alerting service

Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Notes

To order reprints of this article go to:
<http://www.bmjjournals.com/cgi/reprintform>

To subscribe to *Archives of Disease in Childhood* go to:
<http://www.bmjjournals.com/subscriptions/>

"amenities" (quality of refreshments, toys, toilet and disabled facilities), "consultant care" (privacy, listening, use of plain language and involvement in decision making) and "clinic care" (cleanliness, courtesy and understanding the child's needs).

Seventy nine of the 149 (53%) questionnaires were returned. Of the 79 children, 37 (47%) were male, 42 (53%) were female and 50 (63%) were less than 2 years of age.

Satisfaction with clinical care was high (satisfaction score 4.6). Comments by parents suggested that teamwork and having sufficient time to discuss immunisation were important factors. In England lack of time to discuss immunisation with a health care professional is one of the commonest causes of dissatisfaction with the immunisation visit.²

The "amenities" domain was the lowest scoring (satisfaction score 3.9). Important factors included lack of refreshments (the clinic is located some distance from the canteen) and problems with car parking. Car parking is important for parents with young children and this problem has been reported previously.³ We suspect that it is an important issue in many paediatric outpatient departments.

Similar surveys⁴⁻⁶ have identified high levels of satisfaction with clinical care. This survey highlighted to us that non-clinical factors are important for patient experience and that small changes within the clinic can lead to perceptible improvements for patients.

Kenneth Lamden

Cumbria and Lancashire Health Protection Unit, Central Lancashire Primary Care Trust, Ormskirk, Lancashire, UK

David Baxter

Greater Manchester Health Protection Unit, Eccles, UK

Correspondence to: Kenneth Lamden, Cumbria and Lancashire Health Protection Unit, Central Lancashire Primary Care Trust, Wigan Road, Ormskirk, Lancashire L39 2JW, UK; Kenneth.lamden@centrallancashire.nhs.uk

doi: 10.1136/adc.2006.115600

Competing interests: None.

References

- 1 **American Board of Internal Medicine.** *Using patient satisfaction questionnaires (PSQs) for recertification.* Philadelphia: ABIM, 2002, <http://www.uthscsa.edu/gme/nsgeval.pdf> (accessed 4 April 2007).
- 2 **Yarwood J, Noakes K, Kennedy D, et al.** Tracking mothers' attitudes to childhood immunisation 1991-2001. *Vaccine* 2005;**23**:5670-87.
- 3 **Witchell L, Lester S.** Ask the children - auditing children's services with PALS standards. *Paediatr Nurs* 2005;**17**:34-6.
- 4 **De Bruin C, Howell F, Bedford D, et al.** Outpatient experiences in acute hospitals. *Irish J Med Sci* 2002;**171**:89-93.
- 5 **Robinson RO, Edwards M, Madigan C, et al.** Audit of a children's epilepsy clinic. *Dev Med Child Neurol* 2000;**42**:387-91.
- 6 **Sullivan PB, Burnett CA, Juszczak E.** Parent satisfaction in a nurse led clinic compared with a paediatric gastroenterology clinic for the management of intractable, functional constipation. *Arch Dis Child* 2006;**91**:499-501.

Did you know this medicine has peanut butter in it, doctor?

We were recently contacted by the parents of one of our newborn babies who had been

discharged on Abidec drops as they were concerned that this contained arachis (peanut) oil. On discussion with colleagues we realised this fact is not widely known. The list of relatively commonly used topical preparations that contain arachis oil includes Cerumol (for removing ear wax), Siopel barrier cream, zinc and castor oil ointment, Calamine oily lotion, Dermovate (a potent topical steroid cream used for difficult eczema) and Naseptin cream. Systemic medications containing arachis oil and likely to be prescribed by paediatricians include Abidec multivitamin drops, Isotretinoin capsules (for treating acne), Sustanon (a testosterone injection) and Calogen (a high fat calorie supplement).

Lack *et al*¹ suggested the possibility that sensitisation to peanut protein may occur in children through the application of ointments and creams containing arachis oil to inflamed skin. However, the Committee on Safety of Medicines (CSM) advice is that there is insufficient evidence to conclude that exposure to arachis oil in medicinal products leads to sensitisation to peanut protein.² The Department of Health and the CSM recommend that patients with a known peanut allergy or a family history of peanut allergy should not receive medicines containing arachis oil³ even though work conducted by a Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment in 1998 concluded that refined arachis oil did not contain allergenic peanut proteins.⁴ While we await further guidance on the use of medications containing arachis oil, it is important that paediatricians make themselves aware of these preparations and ensure this is discussed with parents when these drugs are prescribed.

Viktoria Dixon, Shaymau Habeeb, Raman Lakshman

West Suffolk Hospital, Bury St Edmunds, Suffolk, UK

Correspondence to: Viktoria Dixon, West Suffolk Hospital, Bury St Edmunds IP33 2QZ, UK; Viktoriadixon@hotmail.com

doi: 10.1136/adc.2007.120949

Competing interests: None.

References

- 1 **Lack G, Fox D, Northstone K, et al.** Factors associated with the development of peanut allergy in childhood. *New Engl J Med* 2003;**348**:977-85.
- 2 **MHRA.** Medicines containing peanut (arachis) oil. *Current Problems in Pharmacovigilance* 2003;**29**:5.
- 3 **Chapman V.** Abidec® Multivitamin Drops and peanut allergy. UKMi Q&A 95.1 (UK Medical Information 95.1). Available from <http://www.druginfozone.nhs.uk/Record%20Viewing/viewRecord.aspx?id=561128>.
- 4 **Department of Health.** *Annual report of the Committees on Toxicity, Mutagenicity and Carcinogenicity of Chemicals in Food, Consumer Products and the Environment.* London: Department of Health, 1998:17.

When personal and professional collide!

Thank you to Dr Davies and colleagues for their timely reminder about super-hero related injuries¹. My 3-year-old son has a Spider-man bicycle, Spider-man slippers, Spider-man bicycle helmet and Spider-man suit (non-padded). I note this means he is in the highest risk group.

Therefore I warned him not to jump out of windows and break his arm. He reassured me, "No dad - I will not break my arm when I jump out of windows".

John C Furness

County Durham and Darlington NHS Foundation Trust, Darlington, UK; John.Furness@cddft.nhs.uk

Competing interests: None.

Reference

- 1 **Davies P, Surridge J, Hole L, et al.** Superhero-related injuries in paediatrics: a case series. *Arch Dis Child* 2007;**92**:242-3.

Not in my backyard: the state of Scottish academic paediatrics

The review of academic paediatrics by Winyard *et al*¹ identifies an ongoing crisis in recruitment and retention. They seem cautiously optimistic that the introduction of Modernising Medical Careers (MMC) and its dedicated academic clinical fellowship (ACF) programme will halt this decline. We are concerned that the proposals will not be sufficient in Scotland.

Of the 50 ACF posts dedicated to paediatric/child health specialties in the first round, 40 were within London and South England deaneries. Only 10 cover the remainder of England, with all "general paediatric" ACFs being in the Nottingham area.² The second round has an additional nine paediatric ACFs of which a further three are in London.³ Information on Scottish ACFs is difficult to locate for enquiring trainees but six posts per annum are identified that could be used as ACFs.⁴ Paediatrics is not specifically mentioned or included in the specialties where "national shortage has been identified". The lack of awareness of the academic strand of MMC is further evidenced by its omission from the teaching material regarding applications provided by NHS Education for Scotland.⁵

The importance of an academic "role model" is highlighted again.⁶ Who will act as inspiration to foundation trainees and those within paediatrics to consider academia as a career choice? We conducted a postal questionnaire survey of west of Scotland specialist registrar (SpR) trainees over 5 years to establish academic contribution at time of appointment to SpR grade. Thirty four of the 35 trainees responded (97%). Presentation at national or international level was recorded for 20 trainees (58%) with a total of 64 presentations, skewed by a single trainee with 22 presentations. Publication was poor. Only 13 (38%) had any publications at time of appointment. The total of 44 publications by these trainees is also skewed by the same single trainee with 16 publications. Trainees indicating a desire for neonatology or a paediatric hospital-based subspecialty were more likely to have publications or presentations than general or community trainees. If these results are used as a proxy for academic prowess, similar to the Research Assessment Exercise, Scotland is breeding a generation of consultants with limited experience of the vagaries of research. This can only contribute to the "negative attitudes displayed by some non-academic paediatric mentors".

Academic paediatrics has been declining and Winyard *et al* rightly point out that MMC may re-invigorate this vital arm of the specialty. The Scottish experience and poor recognition of

this aspect of MMC suggest that "North of the Border" this is too little, too late.

Ben C Reynolds, T James Beattie, Ian J Ramage
Royal Hospital for Sick Children, Glasgow, UK

Correspondence to: Ben C Reynolds, Royal Hospital for Sick Children, Glasgow, UK; pinkdoc@doctors.org.uk
Competing interests: None.

References

- 1 **Winyard PJD**, Cass HD, Stephenson TJ, *et al.* Developing critical mass and growing our own academics. *Arch Dis Child* 2006;**91**:1027–9.
- 2 **National Co-ordinating Centre for Research Capacity Development (NCCRD)**. Successful Academic Clinical Fellowships: first round. <http://www.nccrd.nhs.uk> (accessed 15 April 2007).
- 3 **National Co-ordinating Centre for Research Capacity Development (NCCRD)**. Successful Academic Clinical Fellowships: second round. <http://www.nccrd.nhs.uk> (accessed 15 April 2007).
- 4 **Scottish Executive Health Department Chief Scientist Office**. Scottish Clinical Academic Training Fellowship Scheme. <http://www.sehd.scot.nhs.uk/cso> (accessed 15 April 2007).
- 5 **Modernising Medical Careers Scotland**. Post foundation training programmes in Scotland. http://www.mmc.scot.nhs.uk/Medical_Students/documents/STPhandoutA4forinternalprint_000.pdf (accessed 15th April 2007).
- 6 **The Academic Careers Committee of Modernising Medical Careers and the UK Clinical Research Collaboration**. Medically- and dentally-qualified academic staff: recommendations for training the researchers and educators of the future. London: UKCRC and MMC, 2005.

The views of professionals toward infant growth

We would like to thank Wright and Weaver¹ for their interesting commentary accompanying the publication of our article.² They comment on the lack of differentiation between the size and growth of infants in the understanding of professionals and parents, and resulting difficulties in interpreting growth charts. When integrating evidence from lay and scientific viewpoints we came to similar conclusions.³

Wright and Weaver also call for a systematic review of professional views about infant size and growth. In our review we did seek out the views of professionals as well as of parents and others, but only located two relevant studies.

The first study reported on questionnaires returned by 263 public health nurses from across Finland concerning post-natal home visits.⁴ Although most nurses who responded (62%) thought that weighing the child at this visit was important, a substantial minority (35%) saw little or no value in weighing.

The second described views on early childhood obesity expressed by 16 dietitians attached to a special supplemental nutrition programme for women, infants and children (WIC) clinics in the USA.⁵ They thought that lack of concern about overweight among parents was problematic. One said "I think unless a family member had a medical problem associated with weight, they really don't see that there is a need for any type of intervention or to do anything".⁵ This study also revealed a degree of antagonism between mothers and dietitians, who sometimes saw themselves as "battling" against the advice of family members.⁵

Patricia Lucas, Catherine Law, Janis Baird, Helen Roberts

School for Policy Studies, University of Bristol, Bristol, UK

Correspondence to: Patricia Lucas, School for Policy Studies, University of Bristol, Bristol, UK; patricia.lucas@bristol.ac.uk

Competing interests: None declared.

References

- 1 **Wright CM**, Weaver LT. Image or reality: why do infant size and growth matter to parents? *Arch Dis Child* 2007;**92**(2):98–100.
- 2 **Lucas PJ**, Arai L, Baird J, *et al.* A systematic review of lay views about infant size and growth. *Arch Dis Child* 2007;**92**(2):120–7.
- 3 **Lucas PJ**, Roberts HM, Kleijnen J, *et al.* The importance of size and growth in infancy: integrated findings from systematic reviews of scientific evidence and lay perspectives. *Child Care Health Dev*. In press. doi: 10.1111/j.1365-2214.206.00718.x.
- 4 **Vehvilainen-Julkunen K**. The function of home visits in maternal and child welfare as evaluated by service providers and users. *J Adv Nurs* 1994;**20**:672–8.
- 5 **Baugcum AE**, Burklow KA, Deeks CM, *et al.* Maternal feeding practices and childhood obesity: a focus group study of low-income mothers. *Arch Pediatr Adolesc Med* 1998;**152**:1010–14.

Blunted inflammatory and faster clinical recovery following laser treatment compared to cryotherapy

We read with great interest the letter of Anand *et al* in this journal on the use of different modes of analgesia and anaesthesia during retinal surgery for retinopathy of prematurity (ROP).¹ We fully agree that the administration of medication for sedation, analgesia and paralysis on the neonatal ward avoids delay in treatment and eliminates the unnecessary transfer of neonates before and following surgery.² We would like to mention an additional point not yet considered in the current analysis, that is, the potential impact of the type of surgery on perioperative management and outcome. Cryotherapy and laser photocoagulation are both effective in preventing visual impairment for threshold ROP. In contrast, there are almost no reports on non-ophthalmological outcome. We therefore retrospectively evaluated the effect of the surgical technique on postoperative clinical management and inflammatory response, based on retrospective analysis of postoperative management of infants who received cryotherapy (2000–2001) or laser photocoagulation (2001–2005) but otherwise underwent the same postoperative standardised approach. Duration of postoperative ventilation and of administration of analgesics and time until full enteral feeding was recommended were recorded. C-reactive protein (CRP) values in the first week after surgery were collected. Retinal surgery was performed in 35 infants. Sixteen infants were treated with cryotherapy and 19 received laser photocoagulation. There were no significant differences in birth weight, gestational age at birth, weight or postnatal age at surgery between both groups. In contrast, a significant decrease in duration of postoperative ventilation (hours, $p < 0.02$) and in duration of intravenous analgesics (hours, $p < 0.03$) was observed. Finally, the time until full enteral feeding was recommended (hours, $p < 0.05$) was significantly shorter in

infants who received laser photocoagulation.³ A similar study on the absence of CRP increase following laser treatment in this journal stimulated us to evaluate the impact of type of surgery.⁴ In the same cohort, data on 56 CRP values were available, of which 31 were in infants after cryoablation and 25 in infants after laser photocoagulation. The median CRP level after cryoablation was significantly higher compared to the median CRP level after laser photocoagulation ($p = 0.02$, all Mann Whitney U tests).⁵

We therefore conclude that the use of laser photocoagulation for threshold retinopathy was associated with a faster postoperative recovery and a blunted inflammatory response compared to cryo-treated infants. The differences in surgical technique might therefore further contribute to the differences in anaesthetic management and postoperative outcome.

Karel Allegaert, Marc Van de Velde

NICU and Anaesthesiology, University Hospital, Leuven, Belgium

Correspondence to: Karel Allegaert, NICU and Anaesthesiology, University Hospital, Leuven, Belgium; karel.allegaert@uz.kuleuven.ac.be

Competing interests: None declared.

References

- 1 **Anand D**, Etuwebe B, Clark D, *et al.* Anaesthesia for treatment of retinopathy of prematurity. *Arch Dis Child Fetal Neonatal Ed* 2007;**92**:154–5.
- 2 **Allegaert K**, Van de Velde M, Debeer A, *et al.* Cryotherapy versus laser photocoagulation for threshold retinopathy of prematurity: impact on short term postoperative management. *Bull Belge Ophthalmol* 2006;**300**:7–10.
- 3 **Allegaert K**, Tibboel D. Shouldn't we reconsider procedural techniques to prevent neonatal pain? *Eur J Pain*, 2007 Mar 16; [Epub ahead of print]. Doi: 10.1016/j.ejpain.2007.01.007.
- 4 **Daniels JG**, Adams GG. Effect of laser photocoagulation for retinopathy of prematurity on C reactive protein. *Arch Dis Child Fetal Neonatal Ed* 2004;**89**:F470.
- 5 **Allegaert K**, Devlieger H, Casteels I. Reduced inflammatory response after laser photocoagulation compared with cryoablation for threshold retinopathy of prematurity. *J Pediatr Ophthalmol Strabismus* 2005;**42**:264–6.

Reducing the burden of atopic dermatitis – authors' response

We read with interest the stimulating comments by Dr Wjst¹ concerning our prebiotic study in infants at risk for allergy.²

Because this was the first study using prebiotics for the prevention of atopic dermatitis, our statistical consultant proposed that the p value should be calculated "conservatively". However, we agree that the single-sided test is more appropriate, which indeed changes the p value from 0.014 (as given in the paper) to 0.008.

We were aware of the fact that the risks by parental history of various allergic diseases are not interchangeable, as described in the paper by Dold *et al.*³ We recorded the allergic diseases of the parents. There was no difference between the two groups with respect to the incidence of parental atopic dermatitis, allergic rhinitis, asthma, food allergy, drug allergy, etc.

Because both study formulas were supplemented with vitamin D (1.3 µg/100 ml), no extra supplementation was administered to the infants. Thus, the vitamin D intake was