



Bans on the sale of toys containing small magnets have been instituted worldwide since 2011, including in Australia.¹ However, our first patient's family obtained the toy from overseas, and the second case occurred after the ban was instituted in 2012. This highlights the importance of continued awareness of this potentially devastating condition among both clinicians and parents. Additionally, tighter, universal regulation upon the sale of novelty items and toys containing multiple magnets may be required to prevent further near-fatal attractions.

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Dear Editor,

RECURRENT ANAPHYLAXIS CAUSED BY TOPICAL POVIDONE- IODINE (BETADINE)

Povidone-iodine (Betadine) is a rare cause of IgE-mediated allergy. We report a case of recurrent anaphylaxis in a 12-year-old girl following the use of Betadine swabs.

The patient initially presented at 9 years old with generalised urticaria, facial angioedema and shortness of breath, following a scratch from a rabbit. She was found to have wheeze and was treated with intramuscular adrenaline. In her history, she had mild corozal symptoms after handling the rabbit, and with a positive skin prick test (SPT) to rabbit (7 × 7 mm), she was diagnosed with anaphylaxis to rabbit scratch. The rabbit was removed from the home.

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She subsequently had a second episode of anaphylaxis at 12 years of age following a cut to her skin. Suspicion fell on the antiseptic Betadine (povidone-iodine), which was used to clean the wound and which her mother recalled also using on the first occasion. SPT was positive (9 × 9 mm), and she was diagnosed with recurrent povidone-iodine anaphylaxis. She was provided with a medic alert bracelet, an adrenaline autoinjector, and was advised where possible to avoid exposure to medicines and other products containing povidone and povidone-iodine.

Povidone-iodine is a stable iodophor solution containing a water-soluble complex of iodine and polyvinylpyrrolidone. Fewer than 10 documented IgE-mediated allergic reactions have been reported following povidone-iodine exposure, occurring after topical, vaginal or rectal applications.^{1–4} The allergenic determinant in cases of immediate hypersensitivity is thought to be povidone, based on the presence of IgE antibodies to povidone in the serum of allergic patients,¹ and the occurrence of anaphylaxis to povidone without iodine,⁵ including in a child who had previously reacted to Betadine.⁶

Povidone is a mixture of synthetic polymers,⁷ which is widely distributed, being used as an additive in food products, a dispersant in hairsprays, a suspending and coating agent in tablets, a film forming compound for eyedrops and a retardant for subcutaneous injections.⁸ It is present in 20% of tablets on the market in Germany⁹ in more than 800 pharmaceuticals products in Japan,¹⁰ and a brief search of MIMS online database (<http://proxy36.use.hcn.com.au/Search/QuickSearch.aspx?ModuleName=Product+Info>) identified povidone in 650 Australian products such as tablets, eyedrops, gargles and skin creams. Unfortunately, although it is compulsory to declare povidone when it is an active ingredient, its declaration as an excipient is less straightforward. For instance, the listing of excipients in product information sheets is not required by the Therapeutic Goods Administration for over-the-counter and complementary medicines.¹¹ Therefore, if a patient is diagnosed as being allergic to povidone-iodine, while avoidance should be advocated,^{7,10} this may be difficult, and given the risk of accidental exposure to povidone, the supply of an adrenaline autoinjector has been recommended.¹⁰

Finally, the long-standing widely held belief that a patient who has had a reaction to one iodine-containing compound (e.g. Betadine or seafood) is at greater risk of reacting to another, such as radiocontrast medium, is not supported by evidence and appears to be a myth.¹²

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Dear Editor,

PAEDIATRIC ASSESSMENT IN A GENERAL METROPOLITAN EMERGENCY DEPARTMENT

There are multiple differences between children and adults that affect the way they present to health-care settings during illness, and medical and nursing practitioners tailor their practice accordingly. Gathering information regarding growth, development, immunisation status and perinatal issues is considered routine in the evaluation of the unwell child. Assessment of these factors has important implications for the child's short- and long-term health. We analysed collection of the above parameters in patients presenting to an emergency department (ED) that assesses and manages both adult and paediatric patients.

We retrospectively reviewed the electronic files of 272 consecutive paediatric presentations (57% male; 25% <3 years, 22% 3–7 years, 22% 8–12 years, 31% 13–16 years) in the ED at The Northern Hospital, Epping, Victoria, Australia, a mixed-age

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Table 1 Summary of results

Parameter	Yes	Partial	No	% recorded
Height	1	0	271	0.4
Weight	85	0	187	31.3
Head circumference	0	0	272	0
Body mass index	0	0	272	0
Growth charts completed	0	2	270	0
Immunisation status	83	3	186	30.5
Developmental history	14	0	258	5.1
Perinatal history	41	0	231	15.1

group general ED in suburban Melbourne, to ascertain whether information regarding growth, development, vaccination status and perinatal issues was recorded. The findings are summarised in Table 1.

Our results are in keeping with a study finding that immunisation status was documented in only 24% of paediatric ED presentations.¹ The low rates of documentation in the ED are in stark contrast to a study that found that 98% of patients admitted to an Australian inpatient paediatric unit had their immunisation status recorded.² The most frequent recorded parameters were weight and immunisation status. There are two possible reasons for this: firstly, paediatric medication doses and intravenous fluid infusion rates are calculated on weight; and secondly, in our hospital, these were the only parameters with specific documentation areas on the paediatric observation chart. This visual cue might trigger doctors and nurses to gather the relevant information, which is in keeping with the evidence that suggests that visual reminders help to reduce the gap between best practice and routine care.^{3,4} In particular, Skull *et al.* found that immunisation status was 2.2 times more likely to be recorded when a visual prompt was used.¹ When they combined visual prompts with staff education, they were able to improve immunisation status documentation from 24% to 46%.

As EDs are subjected to ever increasing time pressures, including factors such as the 4-hour rule, it is important simple tools that help us to practice proactive preventative medicine are not overlooked. Although it is unrealistic to expect that these parameters would be recorded in all cases, they can be useful in the ED setting, for example, calculation of body mass index may lead to referral to a weight management clinic.

Potential solutions include staff education and alteration of the paediatric observation chart to include more visual prompts relating to important information.

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