LETTERS

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Pre-hospital management of infantile gastroenteritis

Sir,

Recommendations for the treatment of gastroenteritis in children have stressed the importance of oral rehydration solutions and withdrawal of milk feeds for 24 hours in bottle fed infants.[1] The use of antibiotics should be limited to specific indications such as giardiasis or shigellosis, and antidiarrhoeal agents should be avoided as they are ineffective and may be harmful.[2]

In view of these recommendations a survey was undertaken to assess the pre-hospital management of infantile gastroenteritis.

Between November 1988 and February 1989 100 patients under the age of two years were admitted to this unit with a primary diagnosis of gastroenteritis. All patients were referred or had been seen by their general practitioners or deputies since the onset of symptoms. Age, sex, duration of symptoms, reason for admission and fluid and drugs prescribed prior to admission were recorded in addition to treatment given on the ward.

There were 59 boys and 41 girls with a mean age of 9.2 months (range 0.5–23). The duration of symptoms ranged from 12 hours to 28 days with a mean of 5.9 days. The commonest reasons given for requesting admission were persistent symptoms (70) and dehydration (20); other reasons were pyrexia (two) and poor social circumstances or mother not coping (eight).

A total of 80 patients received commercially available oral rehydration solutions, seven were instructed to be given fluids only, and in 13 no change in feeding was advised (Table 1). Of the 16 patients given antibiotics nine had significant symptoms prior to the diarrhoea or vomiting such as cough, pyrexia, febrile fit or possible ear infection for which they were prescribed the drugs. Therefore seven patients received antibiotics primarily for gastroenteritis. The most commonly used antidiarrhoeal was kaolin (10) in addition to loperamide (two), and diphenoxylate (two).

Table 1. Pre-hospital management of infants with diarrhoea.

Drugs/fluids	Number of patients
ORS as only treatment	56
ORS and antibiotics	11
ORS and antidiarrhoeals	13
Antibiotics only	4
Antibiotics and 'fluids only'	1
Antidiarrhoeals and 'fluids only'	1
'Fluids only'	5
No treatment	9

ORS = oral rehydration solution. Fluids only: boiled water, salty water, lemonade, fruit juice.

Only one child required intravenous fluids on the ward and three received antibiotics for gut pathogens (salmonellosis (two), shigellosis (one)). Other conditions for which antibiotics were given to inpatients were urinary tract infection (two), ear infection (two) and cellulitis (one).

Two similar studies,[3,4] published in 1984 and 1985, found that only 12–30% of children admitted with gastroenteritis received oral rehydration solutions from their general practitioners, 8–18% were given antibiotics, and 5–20% antidiarrhoeals. The results of this survey show that the use of oral rehydration solutions has increased considerably and is becoming standard treatment in the management of gastroenteritis. However, some drugs, particularly antidiarrhoeals, continue to be prescribed inappropriately to a minority of infants.

Adequate data on the advice given to mothers was not obtained in this study but we believe the management of gastroenteritis in the community could be improved further by general practitioners giving precise instructions on how to administer oral rehydration solutions, for instance giving frequent small volumes from a spoon to a vomiting infant. It remains to be seen whether these changes bring about a reduction in the number of children admitted to hospital with gastroenteritis.

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References

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No endocervical cells

Sir,

What action should be taken on receiving a smear report which states 'No endocervical cells seen'? In my own practice we performed 660 cervical smears last year of which 6% were reported as showing 'no endocervical cells'. This year the figure will probably be higher. In my county this figure is low, and the county average is 31% but there are no clear universal guidelines indicating the significance of this finding. Conflicting advice was given in the *British Medical Journal*[1] but in the final analysis the decision whether to repeat the smear or not was laid firmly at the feet of the doctor taking the smear in the first place. I am reminded of a general practice colleague who had exactly this report on one of his receptionists in whom he felt duty bound to repeat the sample. It returned showing CIN I-II.

I cannot in my own conscience see how the screening procedure can be acceptable if the area in which 70% of squamous cell carcinomas arise has not been sampled. My own approach therefore is to repeat all of them, but I know that this is not a universal habit even within my own practice. On the occasion of a second sample returning with the same report, then I inform the patient of the result and suggest