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Sécurité à domicile: Des objets qui protègent vraiment?

J'achète mieux, 2000; ***287: 6–9***

Commentaire

Selon une enquête de la Fédération romande des consommateurs et PIPAD'ES[1] en collaboration avec l'ACSI (Association des consommatrices de la Suisse italienne) et le BPA (bureau suisse de prévention des accidents), un ménage sur 4 a connu au moins un accident impliquant en enfant de moins de 5 ans.

Dans environ 30 % des cas, l'absence d'équipement de sécurité (cache-prise ou prise de sécurité, barrière pour porte ou escaliers, sécurité pour fenêtre, protection pour four, protège angles, tapis antiglisse, boîte pour médicaments etc.) peut être mise en cause.

L'enquête s'est portée aussi sur les sources d'information: 2113 fois a été mentionnée le magasin, 1356 fois la famille ou des amis, 888 fois la publicité, 678 fois le BPA et … 76 fois le pédiatre.

Faut-il intensifier l'information dans nos cabinets, ou est-ce que nous devrions plutôt collaborer à garantir une information optimale par les canaux qui «marchent»? rs

[1] Programme Intercontinental de Prévention des Accidents d'Enfants, soutenu par les services de la santé publique des cantons de Genève, Tessin et Vaud.

Vaccinations and the Risk of Relapse in Multiple Sclerosis

Confavreux C et al.
N Engl J Med 2001; ***344: 319–326***

Abstract

Background: There has been some concern that vaccination may precipitate the onset of multiple sclerosis or lead to relapses. Since the recent hepatitis B vaccination program in France, there have been new reports of an increased risk of active multiple sclerosis after vaccination.

Methods: We conducted a case-crossover study to assess whether vaccinations increase the risk of relapse in multiple sclerosis. The subjects were patients included in the European Database for Multiple Sclerosis who had a relapse between 1993 and 1997. The index relapse was the first relapse confirmed by a visit to a neurologist and preceded by a relapse-free period of at least 12 months. Information on vaccinations was obtained in a standardized telephone interview and confirmed by means of medical records. Exposure to vaccination in the two-month risk period immediately preceding the relapse was compared with that in the four previous two-month control periods for the calculation of relative risks, which were estimated with the use of conditional logistic regression.

Results: Of 643 patients with relapses of multiple sclerosis, 15 percent reported having been vaccinated during the preceding 12 months. The reports of 94 percent of these vaccinations were confirmed. Of all the patients, 2.3 percent had been vaccinated during the preceding two-month risk period as compared with 2.8 to 4.0 percent who were vaccinated during one or more of the four control periods. The relative risk of relapse associated with exposure to any vaccination during the previous two months was 0.71 (95 percent confidence interval, 0.40 to 1.26). There was no increase in the specific risk of relapse associated with tetanus, hepatitis B, or influenza vaccination (range of relative risks, 0.22 to 1.08). Analyses based on risk periods of one and three months yielded similar results.

Conclusions: Vaccination does not appear to increase the short-term risk of relapse in multiple sclerosis.

Hepatitis B vaccination and the risk of multiple sclerosis

Ascherio A et al.
N Engl J Med 2001; ***344: 327–32***

Abstract

Background: Reports of multiple sclerosis developing after hepatitis B vaccination have led to the concern that this vaccine might be a cause of multiple sclerosis in previously healthy subjects.

Methods: We conducted a nested case-control study in two large cohorts of nurses in the United States, those in the Nurses' Health Study (which has followed 121 700

women since 1976) and those in the Nurses' Health Study II (which has followed 116 671 women since 1989). For each woman with multiple sclerosis, we selected as controls five healthy women and one woman with breast cancer. Information about hepatitis B vaccination was obtained by means of a mailed questionnaire and was confirmed by means of vaccination certificates. The analyses included 192 women with multiple sclerosis and 645 matched controls and were conducted with the use of conditional logistic regression.

Results: The multivariate relative risk of multiple sclerosis associated with exposure to the hepatitis B vaccine at any time before the onset of the disease was 0.9 (95 percent confidence interval, 0.5 to 1.6). The relative risk associated with hepatitis B vaccination within two years before the onset of the disease was 0.7 (95 percent confidence interval, 0.3 to 1.8). The results were similar in analyses restricted to women with multiple sclerosis that began after the introduction of the recombinant hepatitis B vaccine. There was also no association between the number of doses of vaccine received and the risk of multiple sclerosis.

Conclusions: These results indicate no association between hepatitis B vaccination and the development of multiple sclerosis.

Commentaire

Deux études, l'une conduite en France, l'autre aux Etats-Unis confirment, s'il était encore nécessaire, l'absence d'une relation de cause à effet entre la vaccination contre l'hépatite B et l'apparition ou la provocation d'une rechute de sclérose en plaques. rs

Depression and suicide in patients treated with Isotretinoin

N Engl J Med 2001; ***344: 460***

Commentaire

L'auteur, qui souligne exprimer un avis personnel et non la position officielle de la FDA, attire l'attention sur le nombre élevé de dépressions et suicides parmi les patients (d'un âge moyen de 17 ans) utilisant l'isotrétinoïne (Roaccutane®).

Si le nombre de suicides signalé parmi les patients utilisant l'isotrétinoïne ne dépasse pas statistiquement le nombre prévisible à partir de la fréquence globale des suicides aux Etats-Unis et du nombre estimé de personnes exposées à ce médicament, l'isotrétinoïne se situe néanmoins dans le top ten des médicaments signalés à la FDA en relation avec des cas de dépressions et suicides. Dans un certain nombre de cas, la réintroduction du médicament après une pause thérapeutique a été suivie d'une réapparition des symptômes dépressifs.

Nous ne prescrivons pas souvent de l'isotrétinoïne, mais nous connaissons tous des adolescents qui suivent un tel traitement prescrit par un dermatologue. A nous donc d'être attentifs à ce problème, en nous rappelant aussi du lien possible entre acné sévère et dépression. rs

Risk Factors for Cerebral Edema in Children with Diabetic Ketoacidosis

Glaser N et al.
N Engl J Med 2001; ***344: 264–269***

Abstract

Background: Cerebral edema is an uncommon but devastating complication of diabetic ketoacidosis in children. Risk factors for this complication have not been clearly defined.

Methods: In this multicenter study, we identified 61 children who had been hospitalized for diabetic ketoacidosis within a 15-year period and in whom cerebral edema had developed. Two additional groups of children with diabetic ketoacidosis but without cerebral edema were also identified: 181 randomly selected children and 174 children matched to those in the cerebral-edema group with respect to age at presentation, onset of diabetes (established vs. newly diagnosed disease), initial serum glucose concentration, and initial venous pH. Using logistic regression, we compared the three groups with respect to demographic characteristics and biochemical variables at presentation and compared the matched groups with respect to therapeutic interventions and chan-

ges in biochemical values during treatment.

Results: A comparison of the children in the cerebral-edema group with those in the random control group showed that cerebral edema was significantly associated with lower initial partial pressures of arterial carbon dioxide (relative risk of cerebral edema for each decrease of 7.8 mm Hg [representing 1 SD], 3.4; 95 percent confidence interval, 1.9 to 6.3; P < 0.001) and higher initial serum urea nitrogen concentrations (relative risk of cerebral edema for each increase of 9 mg per deciliter [3.2 mmol per liter] [representing 1 SD], 1.7; 95 percent confidence interval, 1.2 to 2.5; P = 0.003). A comparison of the children with cerebral edema with those in the matched control group also showed that cerebral edema was associated with lower partial pressures of arterial carbon dioxide and higher serum urea nitrogen concentrations. Of the therapeutic variables, only treatment with bicarbonate was associated with cerebral edema, after adjustment for other covariates (relative risk, 4.2; 95 percent confidence interval, 1.5 to 12.1; P = 0.008).

Conclusions: Children with diabetic ketoacidosis who have low partial pressures of arterial carbon dioxide and high serum urea nitrogen concentrations at presentation and who are treated with bicarbonate are at increased risk for cerebral edema.

Commentaire

L'œdème cérébral est un événement rare lors d'une cétoacidose diabétique. Néanmoins, la mortalité très élevée de 40–90% – ce qui correspond à la moitié de tous les décès dus au diabète chez l'enfant – fait de cette complication un problème important. Par la définition de facteurs de risque les auteurs contribuent à une meilleure compréhension et approche. rs

Current pediatric indications for cisapride

Vandenplas Y and the ESPGHAN Cisapride Panel.
J Pediatr Gastroenterol Nutr 2000; ***31: 480–9***

Commentaire

Revue bien documentée et pondérée, sur les indications et contre-indications actuelles du cisapride en pédiatrie et sur la place actuelle de ce médicament dans le traitement du reflux gastro-oesophagien. Bilan très utile pour le praticien soumis à un flot d'information à ce sujet. rt

Helicobacter pylori infection in children: recommendations for diagnosis and treatment

Gold BD, et al.
J Pediatr Gastroenterol Nutr 2000; **31: 490–7**

Commentaire

Recommandations établies selon des critères basés sur la «médecine fondée sur des preuves». Cet article définit les examens de laboratoire fiables, l'indication à des examens, l'indication et le choix du traitement. Il complète utilement l'article de J. Spalinger (Helicobacter pylori en pédiatrie: Comment tester, qui tester, quand tester? Paediatrica Vol. 12, No. 1, p. 23–25). rt