et al found that IVMg was not an effective treatment in children with acute episodic viral wheezing and also did not result in a reduction of hospital admission.[2] This inequality may be explained by different pathophysiology between acute episodic viral wheezing and acute asthma. Endobronchial biopsies showed, for example, that the thickening of the epithelial reticular basement membrane and the eosinophilic inflammation characteristics was present in children and adults with acute asthma, but not seen in symptomatic infants with reversible airflow obstruction.[7] It would be interesting to know if differences in IVMg use were also observed in the study of Johnson and if so, were due to lower expectations of efficacy in the younger age group.

We agree that a large randomized controlled trial is necessary to determine the efficacy and safety of early IVMg administration thereby taking into account these 2 age groups. Because administration of IVMg is used as treatment in children with asthma exacerbations, the need for intravenous salbutamol administration and transfer to a pediatric intensive care unit may also be included as outcome measures.

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Reply

To the Editor:

As van Weelden et al recognize, there is ongoing debate and investigation to understand how best to treat children with wheezing, and whether young children with wheezing benefit from the same asthma treatment as older children. Although we did not subdivide our published analysis by age, analyzing children 2-5 years separately from those older than 5 years, our unpublished data include 7737 visits for asthma treatment in children younger than 2 years of age. In 407 of these visits, children received IVMg, and the use of IVMg varied by site, similar to the published dataset. Variation in use of IVMg in children under 2 years of age and in children 2-17 years of age would suggest similar variability is expected in children 2-5 years of age. We agree that only in a prospective clinical trial can we expect to learn whether intravenous magnesium is effective in these children.

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Neonatal antibiotics and infantile colic in term-born infants

To the Editor:

Salvatore et al[1] assessed the prevalence of functional gastrointestinal disorders (FGIDs) in the first year of life and the influence of different neonatal factors on the development of FGIDs. In 42% of term-born infants, infantile colic was diagnosed by the Rome III criteria through standardized interviews at 1, 3, 6, and 12 months. A high percentage of full-term infants received antibiotics at birth (22%), although severe acute infection was an exclusion criterion for the study. An important finding was that antibiotic use in the first week of life was associated with an increased risk of infantile colic in (pre)term-born infants (aRR, 1.24; 95% CI, 1.06-1.45). Unfortunately, no data on the duration of antibiotic exposure were available.