dedicated obesity specialists placed at the level of the primary care trust, use of leisure services, and use of the commercial weight loss sector.

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Clinical course of acute infection of the upper respiratory tract in children: cohort study

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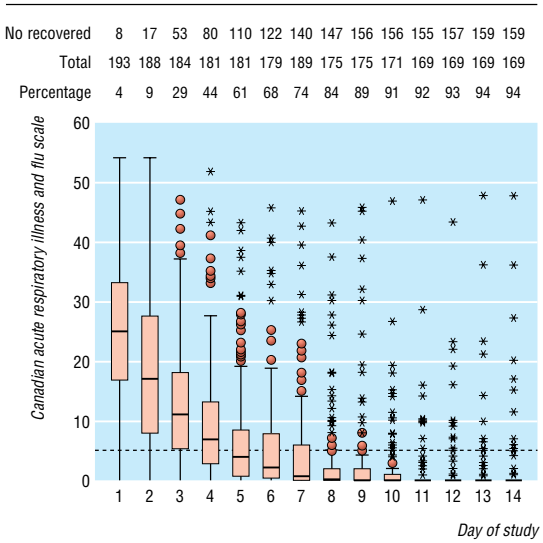
Promoting self care for children with acute viral illness is an opportunity for relieving pressure on primary care. Carers may return for a second consultation and expect antibiotic treatment if they are not given a clear idea of what to expect or if their child fails to recover as predicted.[1] We therefore set out to describe the clinical course of suspected acute viral infection of the upper respiratory tract in children who consult their general practitioner. We wanted to help clinicians to better predict the course of the condition.

Participants, methods, and results

We did a secondary analysis of a cohort from a randomised controlled trial.[2] All carers gave written consent, and older children signed a consent form when recruiting clinicians felt this was appropriate. Fifty five general practitioners in south Wales opportunistically recruited children aged between 6 months and 12 years during routine consultations into a trial of treatment for suspected acute viral infection of the upper respiratory tract. This was an acute illness affecting the upper respiratory tract probably caused, in the clinician's opinion, by a virus. Clinicians excluded children to whom they prescribed antibiotics at the initial consultation. Clinicians compared intranasal treatment with sodium cromoglicate with intranasal saline in a triple blinded manner. Because children treated with intranasal sodium cromoglicate effectively had the same clinical and statistical outcomes as children treated with intranasal saline, we examined data about the clinical course of the condition for the children as a single cohort.



Children's illness over two weeks after consulting their general practitioner with suspected acute viral infection of the upper respiratory tract. Whiskers show largest and smallest non-outlying values; circles show children that are more than 1.5 interquartile ranges from the 25th or 75th centiles (outliers); asterisks show children more than 3 interquartile ranges from the 25th and 75th centiles (extremes); broken line shows score of ≤5 (recovered)

Of the 290 recruited children, 137 (47%) were boys, the mean age was 5.2 (SD 3.39), and mean duration of illness at the time of consultation was 3.3 (2.18) days. Caregivers completed a daily diary of symptoms for up to 14 days which incorporated the 18 item Canadian

acute respiratory illness and flu scale.[3] This scale scores from 0 to 54, and higher scores indicate sicker children. Four of the items on the scale relate directly to the upper respiratory tract—for example, nasal congestion and sore throat—the remainder assess general symptoms of acute infection—for example, irritability and poor appetite. We considered children who scored ≤5 to have recovered. On the fourth day of the study, 101 (56%) of the children had not recovered. On the seventh day, 49 (26%) had not recovered, and, by the 14th day, 10 (6%) had not recovered (figure). Children who had not recovered by the 14th day had remained unwell; their illness did not follow a clinical course with two phases.

Comment

More than half of children with suspected acute viral infection of the upper respiratory tract are still unwell four days after their initial consultation, a quarter are still unwell after a week (about 10 days after the onset of the illness), and one in 20 is still unwell after two weeks. Despite this, doctors may tell carers that children will get better in a few days.[1]

Giving this information to carers may enable them to care for their child more effectively and reduce the need for additional consultations. Being told that a child may have a longer illness could increase requests for treatment, specifically antibiotics, and therefore clinicians must be confident in communicating potential benefits and risks of treatment. Alternatively, carers who know what to expect may not consult when their child's illness lasts for more than a few days.

We thank the trial steering committee, the data monitoring and ethics committee, the caregivers and children who took part, and the clinicians who recruited the children. See bmj.com

Contributors: CCB conceived the study. CCB, PK, KH, and MR developed the protocol. CCB, HP, MR, PK, KH, and HH collected data, managed the study, and wrote and interpreted the report. KH led the analysis. SR helped write and interpret the report. CCB is guarantor.

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A memorable patient

The expert

The *BMJ* leads the way among medical journals in emphasising the importance of patients having a voice and the concept of the expert patient.[1] I have recently had the privilege of meeting a patient who is expert in the anticancer properties of vitamins and nutrients and in anticoagulation. His knowledge, skills, and attitudes have probably prolonged his life. Doctors and patients may learn from his experience on several levels.

He presented with a colon carcinoma in 1994 (at age 65) and subsequently had a liver metastasis. He underwent resection of the primary tumour and the liver metastasis and was deemed to be in clinical and radiological remission. In 2001 his cancer recurred in the form of a second liver metastasis. A further attempt to excise the liver lesion failed, and a surgical opinion in one country suggested that nothing further could be done with regard to resection or chemotherapy.

The patient's review of the relevant literature gave him hope that further resection and remission might be possible. He travelled to another country, where a second surgical resection of his liver metastasis was successful. This was followed by a short course of chemotherapy. His carcinoembryonic antigen levels fell but remained above normal.

After additional extensive research, the patient started taking a self prescribed cocktail of vitamins and nutrients. He titrated the dose of each vitamin and nutrient to minimise toxicity and maximise efficacy, using his carcinoembryonic antigen level as an index of tumour activity. He currently takes the following vitamins and nutrients daily: vitamin C 1150 mg, vitamin E 10 mg, L-lysine 1500 mg, L-proline 1125 mg, conjugated linoleic acid-6 4000 mg, brewer's yeast 3000 mg, selenium 0.2 mg, garlic 1200 mg, probiotic 5 billion units, α-lipoic acid 200 mg, acetyl-L-carnitine 250 mg, coenzyme Q10 60 mg, milk thistle 176 mg, lycopene 250 mg, glucosamine sulphate 1000 mg, chondroitin 800 mg, copper 3 mg, L-arginine 750 mg, *N*-acetyl cysteine 300 mg, manganese 1.5 mg, green tea extract 1800 mg. His carcinoembryonic antigen level is currently undetectable with this regimen.

In 1998 he developed an above knee deep vein thrombosis after an operation unrelated to his cancer, and was treated with heparin and warfarin. He had a further deep vein thrombosis in 2002 and was referred to me for an opinion on the optimal duration of his warfarin therapy. I explained to him the interactions between thrombosis and cancer. I also explained the risks and benefits of stopping warfarin, continuing warfarin in therapeutic dose, and continuing warfarin with a view to keeping his INR minimally prolonged. I mentioned a recent relevant paper in the *New England Journal of Medicine*.[2] He indicated that he was familiar with these research findings.

At the end of a satisfying and mutually enlightening discussion, he elected to take low dose warfarin with a view to minimal prolongation of his INR. We will review him intermittently in the anticoagulation clinic. He is aware that alteration of some of his supplements may interfere with the metabolism of warfarin.

This was the shortest new patient consultation in clinic that morning. The patient declined the offer of co-authorship of this article to preserve his anonymity.

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We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. Please submit the article on http://submit.bmj.com Permission is needed from the patient or a relative if an identifiable patient is referred to.