

participating in the Avon longitudinal study of parents and children, Bingley and colleagues (p 322) tested for antibodies to tissue transglutaminase and then IgA antiendomysial. The 54 children who tested positive for the second enzyme were shorter and weighed less than age and geographically

matched controls who had tested negative in the first stage; half had diarrhoea, and more were girls. Less than 10% of children with suspected coeliac disease were receiving a gluten-free diet. The benefit of early diagnosis of subclinical coeliac disease remains unproved, but the disease can be diagnosed in childhood.

## POEM\*

### Prolonged antithrombotics do not improve unstable coronary syndrome

**Question** Is a prolonged period of antithrombotic pretreatment effective for reducing adverse outcomes in patients with unstable coronary syndromes?

**Synopsis** Because of the risk associated with percutaneous coronary intervention (PCI) and coronary artery bypass graft (CABG) surgery in patients with unstable coronary syndromes, some experts have recommended an extended period of antithrombotic therapy (“cooling off”) before intervention. In this single blinded, randomised controlled trial, eligible patients had symptoms of unstable angina plus either ST segment depression or raised cardiac troponin T concentrations. Patients with evidence of extensive myocardial infarction (ST segment elevation of at least 1 mV in two or more contiguous leads, creatine phosphokinase MB > 3 times normal, or haemodynamic instability) were excluded. Half the patients were aged over 70 and a third were women. Subjects were randomly assigned (uncertain allocation concealment) to antithrombotic pretreatment for 3-5 days or early intervention after pretreatment for less than six hours. Antithrombotic pretreatment included unfractionated heparin, aspirin, clopidogrel, and tirofiban. Other standard treatments, including  $\beta$  blockers, ACE inhibitors, statins, and nitrates, were given when clinically indicated. Thirty day follow up was 100%. Outcomes were assessed by individuals blinded to treatment group assignment. The median time to catheterisation was 86 hours in the prolonged group and 2.4 hours in the immediate group. Definitive treatment including either PCI or CABG was the same in both groups. With intention to treat analysis, the cumulative incidence of extensive myocardial infarction or death was statistically greater in the prolonged antithrombotic therapy than the early intervention group (11.6% (3 deaths, 21 infarctions) *v* 5.9% (0 deaths, 12 infarctions);  $P = 0.04$ ; number needed to harm = 17). Major bleeding complications occurred at a similar rate in both groups.

**Bottom line** In patients with unstable coronary syndromes, prolonged intense antithrombotic pretreatment before coronary intervention compared with immediate intervention results in an increased risk of recurrent myocardial infarction or death. Primary care clinicians caring for these patients should start immediate antithrombotic treatment and refer for definitive coronary intervention as soon as possible.

**Level of evidence** 1b (see [www.cebm.net/levels\\_of\\_evidence.asp](http://www.cebm.net/levels_of_evidence.asp)). Individual randomised controlled trials (with narrow confidence intervals).

Neumann FJ, Kastrati A, Pogatsa-Murray G, et al. Evaluation of prolonged antithrombotic pretreatment (“cooling-off” strategy) before intervention in patients with unstable coronary syndromes. A randomized controlled trial. *JAMA* 2003;290:1593-9.

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\* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

## Editor's choice

### The sudden death of a child

“The sudden unexpected death of an infant or child is one of the worst events to happen to any family.” This is the opening line of a review by authors from Bristol of how best to investigate such deaths and care for bereaved families (p 331). Such a death presents great difficulties to doctors, social workers, and the police, and the difficulties have been increased by the publicity surrounding wrongful conviction of parents of murder. Every primary care trust is supposed to have a “designated doctor” to serve on child protection teams, but a third of these posts are unfilled (p 307).

The management of sudden deaths of infants would be extremely testing even if the doctors could be confident that they were all due to natural causes. But they can't be. A study of 456 deaths and 1800 age matched surviving controls showed that 21 deaths (nearly 5%) were directly due to non-accidental injury. In another 22 deaths maltreatment—through either commission or omission—was thought to have contributed. How can investigators distinguish the 10% of cases where abuse may be a factor from the 90% where it is not?

The first aim of the investigators, writes the Bristol team, must be to recognise the needs of the family, including the need for information. Next they must identify any underlying medical cause that might have genetic or public health implications. There must also be a thorough investigation to exclude unnatural causes of death. Other children must be protected. But families must also be protected from false or inappropriate accusations.

Success in these investigations depends on doctors, social workers, and police working closely together. The Bristol team has systematically reviewed the evidence in order to devise an optimum protocol for investigation. The first step is for all the investigators to meet together as soon as possible after the death to plan the investigation. The paediatrician and police officer then usually see the family together in the emergency department. Next they make a joint home visit with the family doctor or health visitor. A full history is needed together with a careful review of the circumstances and scene of the death.

A careful postmortem is essential, and this has been made more difficult by public reaction to previous practices of tissue or organ retention. An evidence based protocol has now been devised which combines a minimum number of tissue samples with radiological, microbiological, and biochemical investigations. If major concerns are raised about child protection then police or social workers take the lead, but the doctors stay involved.

Two to three months after the death all the professionals meet and reach conclusions. The family is given a written explanation in plain English of the cause of death and the results of pathology investigations—and a chance to discuss the findings.

This is enormously important work, and it's in the interest of everybody that there are good people to do it and that it's done optimally.

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