who deal with victims of child abuse must fully understand and be ready to explain how these patients differ from victims of child abuse. They must also be ready to counter defense arguments that retinal hemorrhages were the result of trivial trauma, as is often proposed by child abuse perpetrators.

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9/35/103499
doi:10.1067/mpd.2000.103499

REFERENCES

1. Christian CW, Taylor AA, Hertle RW, Dubaime AC. Retinal hemorrhages caused by accidental household trauma. J Pediatr 1999;135:125-7.
2. Johnson DL, Braun D, Friendly D. Accidental head trauma and retinal hemorrhage. Neurosurgery 1993;33:231-4.

To the Editor:

It is not clear to me that the article on retinal hemorrhage by Christian et al[1] has added any new information. Retinal hemorrhages are a very reliable, though imperfect, indicator of head trauma, but no one would argue that the presence of retinal hemorrhages automatically indicates non-accidental injury. Determining the intent of the caretaker or circumstances of injury depends on history and investigative confirmation.

Regarding that investigation, I am not reassured in cases 1 and 3 by statements that social work evaluations revealed "no risk factors or concerns" about possible abuse. Even in case 2, a neighbor's telephone agreement seems to be weak evidence.

I am immediately reminded of my colleagues' babysitter-injured child with brain damage and the murdered child in whose case I testified this week. Both were cleared to return to their pre-morbid environments after their first injuries.

If one accepts cases reported by Christian et al as accidental trauma, the unsurprising conclusion seems to be that head trauma may cause retinal hemorrhages and that the cause of trauma should be carefully investigated. It is that second part that still leaves me uneasy.

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9/35/103500
doi:10.1067/mpd.2000.103500

REFERENCE

1. Christian CW, Taylor AA, Hertle RW, Dubaime AC. Retinal hemorrhages caused by accidental household trauma. J Pediatr 1999;135:125-7.

Reply

To the Editor:

We appreciate the responses to our article. We used the term *household trauma* to describe injuries that occurred in the home by accidental mechanisms. The type and neurologic severity of a given injury relates to the specific magnitude and types of forces experienced by the brain and its coverings. In the cases reported here, the neurologic outcomes of the children were good, reflecting the fact that the primary injuries to the brain itself were not severe, but that sufficient surface impact and/or angular deceleration was present to lacerate or rupture cortical vessels. Such occurrences are uncommon, and we by no means suggest that low-height falls, the most common type of household trauma, typically cause retinal hemorrhages. Rather, we noted that retinal hemorrhages caused by accidental trauma were uncommon in our population, occurring in less than 1 of 500 children admitted to our hospital with head injury. Nonetheless, we believe it is useful to point out that in some unusual cases of accidental trauma with the requisite biomechanics, hemorrhage into the subarachnoid, subdural, and retinal compartments may occur.

Dr Lynch correctly points out that the systems in place for evaluating and protecting abused children are flawed, and permanent or fatal injuries can occur when children are returned to abusive environments. The findings in the cases profiled in the article, however, underscore the need to remain objective in evaluating pediatric injuries. In contrast to the experience of Dr Lynch and Dr Coats, in our experience, traumatic retinal hemorrhages oftentimes *are* assumed to be evidence of non-accidental injury by practitioners who know of the strong association between this finding and non-accidental mechanisms but are unfamiliar with the exceptions to that association. The severity of retinal bleeding, although relatively mild in our examples, cannot be used to judge the mechanism of trauma, because some children with severe abusive brain injury have little or no retinal hemorrhages.

Until the mechanisms to protect children and help families are improved or more foolproof methods for differentiating causes of injury are discovered, physicians have a responsibility to recognize that both abusive and accidental trauma may vary in their manifestations. Missing child abuse when it exists can have a tragic outcome, but the consequences of a false accusation, and even conviction of abuse, to a family are not inconsiderable. It is for this reason that all available data should be brought to bear when an opinion on the cause of a specific injury is formed.

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Fixed drug eruptions in children

To the Editor:

We enjoyed reading the report of Morelli et al on fixed drug eruptions in children published in March 1999. Trimethoprim-sulfamethoxazole is the most common causative agent in our experience, also. However, we were surprised to see acetaminophen and paracetamol listed as two different drugs. These two names are synonyms for the same medicine in the medical literature. We wonder whether there were any differences in the additives or other substances used during the man-

ufacture of different brand names. If there were no differences, acetaminophen and paracetamol are identical, and they should be listed together.

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9/35/104023
doi:10.1067/mpd.2000.104023

Reply

To the Editor:

In response to the question posed by Dr Tarim et al.

You are correct that acetominophen and paracetamol are the same active ingredient. We used the names separately because the data were obtained from various countries where the drug is known by different names. The data for these drugs could be listed together.

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CORRECTION

In the article "Issues related to subspecialty education: Weasel words in action," by James A. Stockman III, MD, which appeared in the December 1999 issue of The Journal (volume 135, pages 669-74), Table I was incorrectly reproduced. The correct version appears below.

Table I. Le Mot Juste

Performance percentile	Descriptor
99	Magnificent
98	Superlative
93	Extraordinarily strong
88	Notable
83	Wonderful
80	Terrific, radiant, and humble
78	Accomplished
75	Non-steroidal anti-inflammatory
70	Well read
65	Capable
60	Intermittent
55	Well above the mean
50	Strong
45	Hearty
40	Friendly
35	Well groomed
30	Attentive and respectful
25	Pleasant
20	Punctual
15	Imminently about to blossom
12	Present and fully continent of all excreta
10	Normocephalic and nonfelonious
8	Claudicative
6	English speaking
5	Ambulatory
3	Respirating and well perfused
1	Charmingly fresh in outlook
0	Eukaryotic and possible diploid

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