A patient's story

J, aged 2 years and 6 months, became unwell over 12 hours with fever and vomiting. His parents found two petechial spots. They recognised these as non-blanching and brought him to the emergency department at midnight. On arrival, he was irritable and unwell but afebrile. He was tachycardic (150/minute) and normotensive, with a prolonged capillary refill time (more than 4 seconds). He had oxygen saturations of 100% in air and was breathing normally. Over the next hour a petechial and purpuric rash evolved all over his body. Venous access was established, and he was given intravenous cefotaxime within half an hour of arrival, followed by two boluses each of 20 ml/kg saline. An arterial line was sited, and he was transferred to the high dependency unit. His C reactive protein was moderately raised (58 mg/l) and his white cell count and differential were normal, but clotting studies were abnormal (platelets 146×10^9/l, international normalised ratio 1.5, prothrombin time ratio 2.3, with raised fibrinogen resulting from disseminated intravascular coagulation). His condition stabilised but then deteriorated steadily four hours later; he was ventilated and admitted to a paediatric intensive care unit 11 hours after the original admission. Before transfer, he needed resuscitation with 350 ml/kg fluid intravenously (normal saline, albumen 4.2%, fresh frozen plasma, and blood because of supervening anaemia, totalling more than four times his circulating blood volume since admission). Inotropes (dopamine, then dobutamine and adrenaline) were started. He was treated with haemofiltration for several days in intensive care. Blood culture was positive, and polymerase chain reaction confirmed Meningococcus serogroup B, serotype 15, subtype P1.4. He needed treatment for extensive skin scarring later, but he recovered fully and had no neurological detriment two years afterwards.

serogroup A organisms. Travellers to this area and pilgrims on the annual Hajj to Mecca are advised to be immunised against serogroup A disease. Vaccines for group B disease suitable for routine use in young children have not so far been developed. The possibility of protection against meningococcal disease by blocking pharyngeal binding with *Neisseria lactamica* is intriguing,[w9] but it only tackles one aspect of the predisposing conditions for meningococcal infection.

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Corrections and clarifications

Evidence based diagnosis: does the language reflect the theory?

We introduced an error into figure 1 of this analysis and comment article by Matt T Bianchi and Brian M Alexander (*BMJ* 2006;333:442-5, 26 Aug). When we redrew the figure that the authors had supplied, we omitted a zero from the three likelihood ratios at the lower end of the scale; the correct values should be 0.001, 0.002, and 0.005.

Effectiveness of discontinuing antibiotic treatment after three days versus eight days in mild to moderate-severe community acquired pneumonia: randomised, double blind study

The authors of this paper, Rachida el Moussaoui and colleagues, have alerted us to some small errors they made when writing their article (*BMJ* 2006;332:1355-8, 10 Jun). These occurred in table 2 of the full version text on bmj.com and in the accompanying text. In the per protocol analysis on day 10 the difference between the two arms should be −0.7% (−10% to 9%) [not 0.1% (−9% to 10%)], and in the per protocol analysis on day 28 the difference should be 3% (−9% to 15%) [not 2% (−9% to 15%)]. However, the authors confirm that the text is correct in explaining these differences and that the conclusions drawn are not affected by the errors.

Obituary: Fred Mosteller

In this obituary by Caroline Richmond we were wrong about Fred Mosteller's cause of death (*BMJ* 2006;333:399, 19 Aug). He did not die from diabetes (nor did he have diabetes); he died from sepsis.