tocopherol acetate resulted in mean base-line plasma tocopherol levels of 0.6 mg/dL in premature infants[1] was unfortunately obscured by my proof reading error in not converting the units used by Myers et al, 6 mg/L, to the more conventional 0.6 mg/dL. This confusion led Bowen and Johnson to believe I was discussing the free tocopherol being tested in the report. My point, instead, was that infants in the study of Myers et al had been receiving hyperalimentation solutions including standard multivitamin supplements before being given the experimental free tocopherol. Their plasma levels were in the adequate range (usually considered to be more than 0.5 mg/dL) while receiving these hyperalimentation multivitamins at the zero time base line (mean 0.6 mg/dL, range 0.4 to 0.8 mg/dL). The value of 1.1 mg/kg/d as the approximate amount of tocopherol acetate received through the multivitamins was given to me by the authors at the poster presentation of this abstract in May 1984.

The title of my commentary was meant to draw attention to the adverse events that occurred and what their possible explanations could be. There was no intent to lay blame, merely to salvage some good from this event. If some of us have learned to call the FDA more readily, and if more have learned that new drug formulations must be tested in animals and controlled clinical trials before generalized use, then the loss of life due to E-Ferol IV will be a little less painful.

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REFERENCE

1. Myers PR, Quissell BJ, Peterson RG: Pharmacology of intravenous vitamin E in the very low birthweight (VLBW) newborn. *Pediatr Res* 1984;18:157A

## ERRATUM

In the article "Atrial Overdrive Pacing for Conversion of Atrial Flutter in Children" by Campbell et al (*Pediatrics* 1985;75:730–736), there are several errors in the "Addendum." The "Addendum" should read: Since submission of this manuscript, six additional patients (aged 2, 4, 6, 7, 14, and 17 years; three with transposition/Mustard, one with postatrial septal defect repair, one with post total anomalous pulmonary venous connection repair, and one with a structurally normal heart) with atrial flutter (flutter cycle length *180, 170, 240, 240, 230, 200*, respectively) have received atrial transesophageal overdrive pacing. *Three* were converted to sinus rhythm. Two were converted to sustained atrial fibrillation and the 4-year-old patient with the shortest flutter cycle length was paced to refractoriness. The three who were not converted received elective successful DC cardioversion. This more recent experience reduces the success of the transesophageal method to 65%, a figure that closely approximates the response to the intracardiac method. Despite this recent experience, transesophageal overdrive pacing remains a valuable technique in the management of atrial flutter as well as in other supraventricular tachycardias in children.

# ERRATUM

*Pediatrics* 1985;76;143

**ERRATUM**

*Pediatrics* 1985;76;143