many were keen to stop smoking but weren't sure how to go about it.

After discussion on a viable intervention strategy, we felt that something 'cool' and innovative was called for. Step forward 'Mr Butt', a Facebook character based on a fictional 14-year-old boy. This champion of quitting smoking is everyone's pal and can be added as a friend on this vastly popular networking tool. Mr Butt's group on Facebook, 'Mr Butt wants everyone to quit smoking', is a source of information to learners about smoking, its dangers, and ideas on quitting the habit. Learners were informed about their new online friend and his group and encouraged to seek further information via him by accessing the web on their cell phones.

Much of the existing literature concludes that social support is a vital component of quitting smoking, and the Facebook interface provides us with the opportunity to give support to adolescents dealing with problems that may not be easy to share with family or face to face with peers. The Internet and its various social networking websites could perhaps be the next step in breaking through to teenagers in terms of health promotion.

Fictional Facebook, Mxit and Twitter characters and their groups could be used by doctors and the health authorities to get through to this traditionally neglected age group, the teenager in the corner playing on his cell phone.

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The costs of a bullet – the true cost of labour

To the Editor: I read with interest the paper by Norberg *et al*.[1] in which they admittedly underestimated the in-patient costs of bullet injuries at Tygerberg Hospital. I note that staff salaries, laboratory and pharmacy costs were unavailable.

The latter two missing items are surprising because the National Health Laboratory Service bills the relevant hospital for services rendered, and the pharmacy manufacturers bill Province for drugs supplied.

Salary costs are more difficult. Some years ago while working on my PhD I looked into the true costs of labour. I had a long conversation with a man from the then Commission for Administration who told me that he had been investigating this same problem. He had identified 54 separate items that contributed to the employment costs of government labour. Some are immediately obvious such as salary, pension, medical aid, sick and annual leave, and holiday with pay. He included proportionate costs of the office furniture, carpets, heating, salary clerk, tea drunk, telephone, etc. and even toilet paper!

The conclusion was that a civil servant costs the taxpayer salary plus 100%. Therefore if the employee is timed, and the cost of materials added, the true cost of that particular job can be calculated. Unfortunately this was not published because it would have embarrassed the government.

I therefore recommend that when any future researchers try to cost disease management in the government sector they should use this formula.

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1. Norberg J, Nilsson T, Eriksson A, Hardcastle T. The costs of a bullet – inpatient costs of firearm injuries in South Africa. *S Afr Med J* 2009, 99: 442-445.

Dr Norberg *et al*. reply: We thank Dr Craven for his remarks on our recent scientific letter and acknowledge his comments as valuable and relevant. In response we would like to explain that the NHLS data and pharmacy costs were not included because point of care labs are often used and these are difficult to cost – they are used actively in the Trauma Unit. Secondly, at the time of the study the drugs issued by the emergency pharmacy were not linked to the individual patient folder, only to the pharmacy record, and anaesthetic drug costs were not linked to the files, only to the anaesthetic record.

This was an important confounder, as many patients attended after hours. The labour costs were excluded owing to inability to determine for each individual patient exactly how many staff members interacted with him or her during an admission. We wanted to look at the costs we could reflect accurately. We realise that the true costs are far higher.

Linezolid dosing for staphylococcal pneumonia in children

To the Editor: We have noticed that the dose recommendation for linezolid use in our Guideline for VAP in children, recently published in the *SAMJ*,[1] is incorrect.

Results from studies in paediatric patients have demonstrated that there are age-related differences in the pharmacokinetic parameters of linezolid.[2] Children <12 years old have a smaller area under the Cmax curve (AUC), a faster clearance and a shorter elimination half-life than adults. Newborn infants have clearance values similar to those of adults. However, clearance increases rather markedly

during the first week of life, to values 2 - 3 times in excess of those observed in older children and adults. The clearance of linezolid declines gradually in young children, becoming similar to that of adults by adolescence. After the age of 12 years, the pharmacokinetic parameters for linezolid are not significantly different from those of adults. The age-related changes in linezolid pharmacokinetics have implications for the appropriate dosing of the drug. These findings support the need for a shorter dosing interval in infants and young children to provide adequate drug exposure. In particular, more frequent administration will increase the AUC and plasma trough concentrations. This is important because the AUC:MIC ratio and the time above the minimum inhibitory concentration (MIC) are important determinants of linezolid efficacy against Gram-positive pathogens.

The recommended dosing guidelines for linezolid according to age are that, for most indications, children <12 years old should receive linezolid **10 mg/kg every 8 hours**. The only exception to this is the treatment of uncomplicated skin and skin structure infections, for which the 8-hourly schedule is recommended only for children <5 years old. Because of the lower systemic clearance values and higher AUC values in preterm infants <7 days old, a dosing regimen of 10 mg/kg every 12 h should be initiated for these neonates. However, a 10 mg/kg every 8 h regimen should be considered for those with inadequate clinical response. In addition, the dosage should be changed to 10 mg/kg every 8 h for all neonates by the 7th day of life.

We trust this clarifies the issue.

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1. Morrow BM, Argent AC, Jeena PM, Green RJ. Guideline for the diagnosis, prevention and treatment of paediatric ventilator-associated pneumonia. *S Afr Med J* 2009; 99: 253-267.
2. Jungbluth GL, Welshman IR, Hopkins NK. Linezolid pharmacokinetics in pediatric patients: an overview. *Pediatr Infect Dis J* 2003; 22: S153-157.

Withdrawal of published paper

Please note that the article entitled *Firearm fatalities in the Transkei region of South Africa, 1993 - 2004* by B L Meel (*S Afr Med J* 2005; 95(12): 963-967) has been withdrawn because of duplicated publication.