Correspondence

Archives of Disease in Childhood, 1976, 51, 484.

Sterilization of children under 16 years of age

Sir,

The Department of Health and Social Security has recently prepared a discussion paper on 'Sterilization of Children under 16 Years of Age'. The document has had wide distribution and views have been sought from a large number of organizations, particularly the professions likely to be involved, together with a range of organizations concerned with the welfare of children. Because this is a subject of especial concern to paediatricians, the British Paediatric Association would like to make its comments more widely known.

There are two distinct groups to be considered: the first in which sterilization proves unavoidable in the course of treatment of a serious medical condition (therapeutic sterilization), and the second in which sterilization of children with severe mental handicap is undertaken in order to prevent the possibility of pregnancy (nontherapeutic sterilization). In some of the latter cases the fetus may also be at considerable risk (e.g. maternal phenylketonuria).

In the case of therapeutic sterilization the decision must be made by the doctor in charge of the case. In an important issue of this kind it would be advisable to follow the normal practice of obtaining a second opinion, but this may not always be possible—for instance when during the course of an operation for cancer involving the pelvic organs the surgeon finds that removal of the uterus and/or ovaries is necessary.

It was suggested in the Department's discussion paper that there may be certain genetic indications. After taking expert advice we are clear that the presence of a genetic condition alone cannot justify sterilization under the age of 16 years.

A decision regarding nontherapeutic sterilization should not be made by a single doctor; there are too many issues concerning the accuracy of diagnosis, prognosis, and genetic implications, etc. Professional consultation should include further medical opinion, and for particular children the opinion of medical social workers, psychologists, and other health workers should be sought. It is understood that confidentiality shall be observed by all involved in these consultations. Full discussion with the parents (and where possible explanation to the child) should, of course, precede the final decision.

Although it will be necessary in all cases to consider the problem against the background of the family including the risks to the baby who might be conceived, the interests and well being of the child concerned (i.e. the girl for whom sterilization is being considered) should be paramount. No parent should be able to secure a daughter's sterilization because it is feared that the child may become promiscuous. Wherever possible decisions on sterilization should be postponed until the age of consent. We realize, however, that in cases of severe mental handicap the individual may never be able to give informed 'consent', and we would wish to see a procedure which safeguards the interests of all such persons irrespective of age.

We are not in favour of a central registry or any form of notification.

Decisions should not be delegated to ethical committees. If after consultation consensus cannot be reached then a Ward of Court Procedure should be followed.

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Poststreptococcal nephritis—still not a rare disease in Thailand

Sir,

Dr. Meadow (1975) reported in the Archives that poststreptococcal nephritis is no longer the main cause of childhood acute nephritis in the Leeds area. This may also be true for other areas of Britain, as he suggested. We report the high incidence of poststreptococcal nephritis from January 1972 to December 1975 as seen at Ramathibodi Hospital, one of the 4 university hospitals in Bangkok, a city of 4 millions population.

Seventy children, 2–15 years old, with hypertension, and with preceding sore throat or pyoderma met the criteria as previously described (Meadow, 1975). ASO titre above 1 : 340, or more than twofold increase upon subsequent determination was considered significant (Petchclai et al., 1973a). Complement levels either determined as C3 complement by a radial diffusion method (Mancini, Carbonara, and Heremans, 1965) or as total haemolytic complement by the method previously described (Petchclai, et al., 1973b) were considered significantly depressed at <80 mg/100 ml or 50%, respectively. 25 of the patients had increased ASO titre, and all had depressed complement levels.

Another 55 children who were not hypertensive but had microscopical haematuria and history of facial oedema of more than a week before referral to the renal clinic, also had depressed complement levels. 10 of them had increased ASO titre. We have not routinely performed throat swab culture since antibiotics are available to the population without prescription. In conclusion, we have seen 125 children with poststreptococcal nephritis in the past 4 years.
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Dr. Meadow (1975) also implied that the attribution of acute nephritis to a preceding streptococcal infection in textbooks should perhaps be altered. This may well be so in Britain, but the textbooks are still right in Thailand.

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REFERENCES

Dr. S. R. Meadow comments:

It is interesting to hear that poststreptococcal nephritis is so common in Thailand. The evidence is impressive. The development of suitable techniques to show depressed serum complement levels has enabled Dr. Tanphaichitr and Dr. Chatasingh to confirm the presence of a streptococcal aetiology for their many cases of acute nephritis in a way that was not possible in Britain 20 years ago when acute nephritis in children was also common.

Meadow and Smithells remain unperturbed about having altered the second edition of their textbook to state that, 'Poststreptococcal nephritis is now uncommon in Britain'. But they will ensure that in the Thai edition this statement is qualified appropriately.

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Severe combined immunodeficiency and trisomy D

Sir,

We report a case of severe combined immunodeficiency and trisomy 13–15 an association which we believe has not been reported before. Relevant clinical and laboratory findings were as follows. (1) Clinical data: typical malformations of trisomy D were present including alopecia and osseous lacunae of the cranium, low-set ears, cleft palate, microphthalmia, coloboma, persistence of ductus arteriosus, umbilical hernia, cryptorchidism, penile malformation, hexadactylysm, and arthrogyrosis. Severe recurrent respiratory, urinal, and gastrointestinal infections, conjunctivitis, and malnutrition were also observed during the 6 months that he survived. (2) Chromosomal and immunological data: trisomy D 47,XY, D+; increased Hb-F values; deficiency of circulating lymphocytes (360/mm³); T-lymphocyte deficit (absence of E-rosettes); deficiency of serum IgG and IgA and partial deficiency serum IgM; negative antibody production in response to antityphoid paratyphoid vaccine; absence of narrow plasma cells. (3) Pathological findings: thymic tissue was searched for, but not found in either normal or ectopic sites; scar tissue fibrotic lymph nodes were found only in lumbar aortic region, the nodes showed poor structural organization, an intense depletion of lymphocytes and an absence of plasma cells; the spleen was reduced in volume, lacked lymphatic follicles and was devoid of germinal centres. Feyrer's patches were not observed. Our case in summary was characterized by a malformation complex of trisomy D associated with a deficiency of both thymus-dependent and bursa-equivalent lymphoid systems.

Diagnosis of Di George's (1968) or Nezelof's syndromes (Nezelof et al., 1964), as well as of other previously described primary deficiencies of T cells (Rezza et al., 1974; Lawlor et al., 1974), were excluded since parathyroid glands were present, blood calcium and phosphorus were normal, and no signs of tetany were observed. Lymphoid cells were also absent in the B-dependent areas of lymph nodes, spleen, and bone marrow. In addition, a humoral immune defect was documented. These data support a diagnosis of combined immunodeficiency. Unfortunately, adenosine-deaminase (ADA) was not studied in our case, but probably was normal since ADA-deficient patients have a small thymus (Yount et al., 1974).

Our case is another argument in favour of the heterogeneity of the combined immunodeficiency syndrome, which probably includes several diseases, with different aetiopathogenetic mechanisms. Our observation should induce clinicians and immunogeneticists to study patients with chromosome changes or with immunodeficiencies more carefully so as to gain further understanding of the inter-relation between genes and immune responses.

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Arch Dis Child 1976 51: 484-485
doi: 10.1136/adc.51.6.484-a

Updated information and services can be found at:
http://adc.bmj.com/content/51/6/484.2.citation

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