transfusion include the post-transfusion syndrome, hepatitis, and prolonged virus excretion by those infected. This leads in turn to infection, during the ensuing postpartum months, of those mothers who are not immune—a serious risk if this occurs at a time when the mother is again pregnant.

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References


Dr. Granström comments:
Our study showed only that in the transfused group of children CMV infection was no more common than in the whole group (3/7 and 48/148 respectively). No hazards were associated with CMV infection of the transfused children, or with perinatal CMV infection of the other children. The exact mechanism or source of the infection could not be identified in this study (cervical virus shedding, virus in maternal milk, etc.) but in every case of perinatal CMV infection the possibility of acquisition from the mother was present. On the other hand, seronegative pregnant women have many other possible sources of virus than their own child, because all children infected with CMV may excrete virus for a long time. 70% of perinatally infected children and 30% of all the children in our study were still excreting CMV at the age of 2 years (unpublished results).

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Respiratory function after repair of congenital diaphragmatic hernia
Sir,
The paper by Landau et al. (Archives, 1977, 52, 282) shows that there is rapid improvement in the respiratory function of the lung in infants soon after the repair of congenital diaphragmatic hernia. In a study carried out in our hospital, changes with growth in these lungs were found to be distension, emphysema, and obstruction.

A recent observation suggests that these patients should be followed for many years after the repair of the hernia. A 15-year-old boy was admitted to our department for severe chest pain related to left pneumothorax. Drainage and aspiration allowed rapid improvement and he was discharged 2 weeks later. A few days later the pneumothorax recurred. Medical treatment was unsuccessful and surgery was required to avoid another recurrence. Notably, this patient had been operated on for repair of a left congenital diaphragmatic hernia at the age of 8 months. The occurrence of pneumothorax in a distended lung 15 years after the repair of a congenital diaphragmatic hernia indicates the need for long-term follow-up of these patients.

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Sternomastoid tumour in preterm infants
Sir,
In view of the rarity of sternomastoid tumour in preterm infants, the following cases are of interest.

Case 1. A female infant was the second born of twins to a 30-year-old primiparous mother who had been in hospital with premature rupture of the membranes and continued loss of liquor amnii for 2 weeks before delivery. Caesarean section was performed at 33 weeks’ gestation. The infant was rotated by internal version for transverse lie and delivered by the breech. Birthweight was 1760 g. She was asphyxiated, hypotonic (Apgar score 1 at 1 minute), and required intubation. Gestational assessment by modified Farr score agreed with the mother’s dates. The other twin, also female, weighed 1280 g and was well from birth.

At age 24 days the infant was noted to have a right-sided sternomastoid tumour. Treatment was started with passive extension exercises to the affected muscle. No torticollis was noted and on review at 68 days the tumour was smaller.

Case 2. A female infant, also the second of twins, was born to a 34-year-old mother who had had one previous normal pregnancy. She was admitted to hospital at 24+ weeks’ gestation with spontaneous rupture of the membranes, and continued to lose liquor amnii up to 32 weeks’ gestation when she went into spontaneous labour. The first infant (male, 1570 g) was delivered by the vertex uneventfully.

The second twin was delivered by breech extraction. Birthweight was 1800 g. She was asphyxiated and hypotonic (Apgar score 1 at 1 minute) and required intubation. Gestational assessment agreed with the mother’s dates. A tumour was noted in the left sternomastoid muscle at age 11 days. No active treatment was advised. At 65 days the tumour was smaller and was not associated with torticollis.

The aetiology of sternomastoid tumours has been discussed at length by Dunn (1974) and Jones (1968). The significance of their association with oligohydramnios, breech presentation, and other conditions predisposing to pressure effects upon the fetus suggests that they may well
be the result of prolonged intrauterine compression. The rarity of reports of these tumours occurring in preterm infants may be attributed to the relatively large cushioning volume of liquor amnii. The 2 cases here reported occurred in the second placed infants of twins in pregnancies with prolonged loss of liquor before delivery. They therefore seem at risk to postural deformity despite their prematurity. Case 1 was delivered by caesarean section, adding to the list of documented sternomastoid tumours occurring in infants so delivered, which seems further evidence that these tumours are not the result of birth injury.

I thank Dr D. Pickering and Dr D. Baum for permission to report these cases.

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References

Total anomalous pulmonary venous drainage in sibs

Sir,

We would like to bring to your attention the rare occurrence of total anomalous pulmonary venous drainage (TAPVD) in sibs.

Case 1. A male, the first-born of a 23-year-old mother, was delivered at term, birthweight 2440 g. After doing well initially he was admitted to hospital aged 2 months with cyanosis, heart failure, and an associated murmur. He was treated with digoxin, frusemide, and antibiotics (for an associated pneumonia), and was referred to the Transvaal Memorial Hospital for Children aged 3½ months.

Cardiac investigation showed TAPVD of the supracardiac type draining into the innominate vein with no obstruction to the ascending vertical vein. At age 4 months he underwent total correction, but during induction of anaesthesia he had a cardiac arrest. He was resuscitated and an anastomosis of the confluence of the pulmonary veins to the left atrium was accomplished under profound hypothermia. Over the 12 hours after surgery his condition worsened and he died without regaining consciousness.

Case 2. A boy was the first-born of nonidentical twins in the mother’s third pregnancy, the second pregnancy being normal with delivery of a term female. His birthweight was 2270 g. Both he and his twin sister appeared to do well until 3 months of age when he had a cyanotic spell and was admitted with bronchopneumonia and in heart failure. He failed to respond adequately to anti-biotics, digoxin, and frusemide, and was transferred to Transvaal Memorial Hospital aged 4 months.

Cardiac investigation again showed TAPVD. Angiography, although showing the ascending vertical vein draining into the innominate vein, did not clearly define a common chamber, because the anomalous pulmonary veins were found to drain into both the common vertical vein and the coronary sinus (mixed type). The lesion was corrected by anastomosis of the common chamber to left atrium and moving the atrial septum across so that coronary sinus drained into left atrium. He is alive and well at age 11 months.

In this family the eldest boy and the youngest boy (who was one of nonidentical twins) both had TAPVD. Few instances of familial occurrence of TAPVD have been described. Gathman and Nadas (1970) were probably the first in noting 2 sibs among 75 patients with TAPVD. Paz and Castilla (1971), from Argentina, then described 2 male sibs with supradiaphragmatic TAPVD and a male cousin with infradiaphragmatic TAPVD. 2 male sibs with identical type of infradiaphragmatic TAPVD were reported from Australia (Clarke et al., 1973). These authors mention another family from the south of France, where both sibs had the infradiaphragmatic form of TAPVD. Delisle et al. (1976), in their large series of post-mortem cases, describe a familial instance of TAPVD to the coronary sinus in one and subdiaphragmatic in the other sib. They also describe TAPVD in two sets of identical twins where the lesion was present in only one of each pair.

To the best of our knowledge there are 7 families where 15 instances of TAPVD have occurred. Furthermore, only 3 sets of twins (2 sets identical, 1 set nonidentical) have been reported and in each instance only 1 twin has been affected.

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