children, overt vitamin D deficiency rickets was diagnosed concomitantly with their coeliac disease. The ages at diagnosis of these three were 7, 10, and 11 months; their ages when first symptomatic were 4, 9, and 7 months. In the other six cases, where no overt rickets was recorded, the ages at diagnosis were 7, 18, 19, 21 months, 2 years 4 months, and 4 years 10 months, the ages when first symptomatic being 4, 16, 6, 8, 8, and 5 months. We are now analysing the time sequences of coeliac disease, rickets and, according to the teeth affected and the extent of hypoplasia, the possible concordance or discordance with the time of mineralisation of the affected areas in the diseased teeth. We feel that rickets, even when not clinically or biochemically evident, as is often the case in untreated coeliac disease, could be relevant to the development of enamel hypoplasia.

D H SHMERLING AND M SACHER
Kinderspital Zürich,
University Department of Paediatrics,
Division of Paediatric Gastroenterology,
Steinwiesstrasse 73,
CH-8032 Zürich

B WIDMER AND E D BEN ZUR
Dental Institute of the University of Zurich,
Plattenstrasse 11,
CH-8028 Zurich

Neonatal effects of maternal therapy with tricyclic antidepressant drugs

Sir,

We read with interest the letter by Ben Musa and Smith (Archives, 1979, 54, 405) on withdrawal symptoms, mainly instability of body temperature and jitteriness, in a neonate affected by maternal clomipramine intake.

In 1972 we reported on three term infants born of mothers who took imipramine during pregnancy.1 Transient, alternating episodes of hypokinesia and jerky movements were seen in all three. One baby convulsed on day 2. Transient tachypnoea and poor peripheral circulation were also common findings. In 1973 Webster2 described another baby with similar symptoms. On the other hand, Shearer et al.3 observed pronounced urinary retention in a neonate secondary to maternal ingestion of nortriptyline. Our third patient too, was irritable and showed 'belly dance' movements before voiding. Although hypothermia is only mentioned by Ben Musa and Smith, it is noteworthy that Wattiaux-De Coninck et al.4 could demonstrate the fixation of radioactive imipramine on mitochondria. The action of imipramine on oxidative phosphorylation, and hence on thermogenesis, could explain the occurrence of hypothermia in some of the affected neonates.

Present data suggest that tricyclic antidepressant drugs, given to the mother during pregnancy, may impair the adaptation of the neonate to extrauterine life.

References

E EGGERMONT
Kinderkliniek,
Academisch Ziekenhuis Gasthuisberg,
3000 Leuven, Belgium

Diagnosis and management of folate deficiency in low birthweight infants

Sir,

I read with interest the paper by Strelling et al. (Archives, 1979, 54, 271). Although the erythrocyte folate levels suggested folate deficiency, the babies were too young to have megaloblastic anaemia. Herbert1 showed that serum folate level decreases early (about 7 weeks) and it takes nearly 19 weeks for the real megaloblast to appear in the bone marrow.

The mean reticulocyte count for the babies was 2.64% (range 0 to 6, Table 1) which would not be expected in real megaloblastic anaemias. The rise of Hb and haematocrit values (such as 0.3 and 1%) in 2 to 4 weeks' treatment are well below a response to treatment.2 Because of the feeding history (including iron supplement), the ages of the babies, and the slightly high reticulocyte count for age, I should like to see studies (such as hydrogen peroxide test and vitamin E levels) to exclude vitamin E deficiency. It is well known that megaloblastic changes of erythroid precursors occur in haemolytic anaemias regardless of the cause.

References

SINASI OZSOYLU
Institute of Child Health,
Hacettepe University,
Ankara 11191,
Turkey

Drs Strelling and Goodall comment:

Professor Ozsoyulu expresses doubts on theoretical grounds that our patients could have had megaloblastic anaemia related to folate deficiency when aged only 5 to
Diagnosis and management of folate deficiency in low birthweight infants.

S Ozsoylu

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