training in this field does not fully meet all the needs of children from birth to adolescence, and that we must be prepared to extend our knowledge and expertise so that the RSCN is more readily accepted in all fields of child care. We need the support of paediatricians and our colleagues. However, if paediatricians are willing to work with nurses who do not have the necessary qualifications, and if our nurse administrators are prepared to accept such nurses, then our position will not only be substantially weakened, but it will also have a detrimental effect on the services available for sick children.

References

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Survival of children with chronic renal failure

Sir,

Last year we reported 10 years' experience with regular haemodialysis and renal transplantation in the treatment of children with end stage renal disease (ESRD).1 We should now like to update this report with the results from 1979 and 1980.

By 31 December 1980, 98 children, aged under 15 years, had been accepted for treatment of ESRD. Eighty-eight of these children have received 111 renal allografts (88 first grafts, 19 second grafts, and 4 third grafts; 50 live related donor grafts and 61 cadaver grafts) and 65 of them currently have a functioning graft, 10 are on dialysis, and 13 have died. Of the 10 children not transplanted, 4 were maintained on haemodialysis, 2 children (aged 10 months and 2½ years) were on hospital peritoneal dialysis awaiting cadaver grafts, 1 with the haemolytic uraemic syndrome had recovered renal function after 12 months on home haemodialysis, and 3 had died.

Actuarial patient survival in all 98 children accepted for treatment of ESRD was 81% at 5 years and 78% at 10 years, while the 5-year survival rate for the 66 children treated in the six years since 1 January 1975 was 90%; at 31 December 1978, the 5-year survival rate for all children treated was 76% and that for the 57 children treated during the preceding six years was 83%.

Actuarial graft survival for first grafts performed since 1 January 1975 is shown in the Figure. Live donor graft survival was 86% at 3 years and 76% at 5 years, compared with 71% at both 3 and 5 years for the six years ending in December 1978. First cadaver graft survival has also improved from 47% to 65% at both 3 and 5 years.

The trend towards improved results1 has therefore continued, despite accepting younger children with more complex problems on to the programme. Recipients of cadaver grafts are now transfused on at least five occasions before transplantation and this may have contributed to the improved results.

A grave problem that has become worse during the last 6 months is the poor supply of cadaver kidneys for transplantation and we especially need kidneys from children in order to treat infants and the younger children. We would ask our colleagues to consider contacting their local transplant unit if suitable kidneys become available.

References

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Bed occupancy not an index of efficiency

Sir,

Dr Forrester should be congratulated on his excellent Short Report1 which clearly demonstrates what paediatricians have known for a long time. In our hospital group (and presumably in many others) bed occupancy is counted at midnight; this means that if a child is in with a febrile convulsion for 2 days and 1 night, according to the administrators his bed is occupied for only one day, making the statistics even more confusing.
There were neonatal problems including a case of acrodermatitis enteropathica. A girl hoped breast-fed. Case report

Like Sir, breast-fed infant. Dr Forrester comments:

I am pleased that my paper struck some chords as was shown by a recent letter in the Archives and by several letters sent to me, including one from a senior paediatrician in France who wrote 'Il n’y a pas un mot à changer pour décrire la situation que nous avons ici également—et nous avons ici aussi la même incompréhension des administrateurs d’hôpital...'.

It is only fair to add that in 20 years I had no problem with my own hospital administrators who seemed to understand, at local level, the logic of the empty bed. Officially there were no methods for recording the true state of affairs on my ward (see Dr Hardy’s letter) and my figures were obtained from a meticulously kept ward admission book which I started in 1958 and which, to my knowledge, was still being kept in 1980 contrary to the prevailing custom in the hospital which ‘abolished’ such books years ago. I believe that my successors regarded it, as I did, as the main receptacle of truth.

In summary: empty paediatric beds can admit children—urgently; ward admission books are essential; anyone can keep an acute children’s ward full, but it takes hard and thoughtful work by nursing staff and resident doctors to keep it half empty.

Symptomatic zinc deficiency in a breast-fed infant

Sir,

Like Ahmed and Blair we were treating an entirely breast-fed infant with symptomatic zinc deficiency at the time of publication of the paper by Aggett et al. We had hoped that our patient’s symptoms were a transient manifestation of postnatal deficiency but at age 1 year she has now relapsed twice and must be considered as a case of acrodermatitis enteropathica.

Case report

A girl was born at 32 weeks’ gestation weighing 1620 g. There were neonatal problems including a superficial pustular abdominal skin rash (Staphylococcus aureus) which desquamated after treatment. On the special care baby unit she was fed almost exclusively on breast milk and was discharged fully breast feeding 6 weeks after birth.

Two weeks later an eruption started on the neck and perianal regions. From these two sites the eruption spread by lateral extension to affect the face, particularly around the mouth, lower abdomen, gluteal cleft, and upper inner thighs. The toes were also affected. At its onset (and at times of relapse) the mother described the eruption graphically as looking like a burn and seeming sore; the skin became crinkled and then started to peel. On examination the eruption consisted of two large sheets affecting the above sites which were remarkably symmetrical. The edges were scaly and crusted while the skin of the central areas was returning to normal. The nails and hair seemed to be unaffected. Local treatment with a potent steroid-antibacterial-antifungal ointment was effective initially but when stopped the eruption recurred, she became intensely irritable, and stools were loose. At 15 weeks the infant’s serum zinc was 5.8 μmol/l (normal 8.4–23.0), the mother’s serum zinc was 11.4 μmol/l (normal) and her breast milk zinc was probably low at 5.2 μmol/l.1,2 The skin eruption and the baby’s demeanour improved strikingly within 24 hours of starting zinc sulphate 50 mg three times a day. Treatment was stopped after 5 weeks when the serum zinc was normal but 8 weeks later she relapsed and the zinc level had fallen to 5.6 μmol/l. Rapid clinical response occurred when zinc sulphate was reintroduced. A second relapse and response has occurred at age 12 months.

Unlike Aggett’s case, our patient appears to be permanently zinc-dependent, but it is important again to stress that fully breast-fed (preterm) infants can show overt signs of zinc deficiency and that the skin eruption has a characteristic appearance.

References

Bed occupancy not an index of efficiency

Denis Hardy

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