Relationship between urinary and serum growth hormone and pubertal status

Sir,—We read with interest the paper by Crowne et al on the relationship between serum and urinary growth hormone concentrations during puberty. As the authors pointed out, we carried out very similar studies and came to very different conclusions. In our early studies of 24 normal children of both sexes over the full range of pubertal stages we found very good correlation (r=0.79, p<0.001) between urinary growth hormone excretion and overnight mean plasma growth hormone concentration. We have recently extended these studies comparing diabetic and normal adolescents and found the same correlation in both patient groups (r=0.70, p<0.001).

Crowne et al suggest that the discrepancy between their study and ours could be explained by the fact that we studied mostly children in early puberty. In fact the predomiance was in late ( Tanner stages 3–5, n=15) rather than early puberty (stages 1–2, n=9). We have reanalysed our most recent results and still observe the same good correlation between urinary and plasma growth hormone in late (r=0.69, n=17) and early (r=0.71, n=19) puberty in both sexes.

The methodology for measurement of both urinary and plasma growth hormone concentrations was very similar in our studies and that of Crowne et al, and we believe that the important differences between the two studies are the collection methods and the way the urinary growth hormone data are presented. In the majority of their subjects Crowne et al used a 24 hour collection period with a 20 minute sampling interval for the serum profiles, whereas we used overnight collection with 15 minute blood sampling. The relationship between urinary growth hormone excretion and plasma growth hormone concentrations may not be constant throughout the 24 hours.

More importantly perhaps the authors reported urinary growth hormone excretion in relation to urinary creatinine excretion. Whereas this convention may be useful for checking the completeness of overnight urine collections, in this particular case it can be misleading. We have examined overnight urine samples from 151 normal adolescents at different stages of puberty, and demonstrated that the urinary excretion of creatinine increases during puberty (see table). If urinary growth hormone excretion rates are expressed as a ratio of creatinine excretion therefore, it will be difficult to discern any increase of excretion of growth hormone during puberty, and any correlation which exists with plasma growth hormone concentrations will be lost. If a small group is studied over a limited range of puberty stages, this change in creatinine excretion would not be so significant, and indeed Crowne et al did present some data to support this position. In the subgroups of prepubertal children and in the group of six boys in early puberty, significant correlations were seen between urinary growth hormone excretion related to creatinine and mean serum growth hormone concentrations (r=0.82 and r=0.85 respectively).

We believe that a note of caution should be added to the use of urinary creatinine ratios during puberty, and suggest that urinary growth hormone excretion should be expressed as a timed excretion rate without reference to creatinine. In our experience this does reflect overnight mean plasma growth hormone concentrations with some accuracy during normal puberty.

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Malnutrition in children with cancer

Sir,—In their report of energy intake and basal metabolic rate in children with malignant disease receiving maintenance chemotherapy, Bond et al refer to our work exploring the incidence of malnutrition in children with cancer.2 They state that we found nutritional status to be generally adequate at diagnosis but to deteriorate as a result of treatment. In fact we found that nutritional status was frequently inadequate at diagnosis. This finding directly contrasts with nearly all other studies.3 4 Our study of 48 newly diagnosed children with malignant solid tumours showed a marked discrepancy in the incidence of malnutrition assessed by conventional means when compared with arm anthropometry. Using conventional indices of weight for height, and height for age (as used by Bond et al themselves) only 7% of our patients were assessed as being malnourished at diagnosis. However, using arm anthropometry (mid upper arm circumference and triceps skinfold thickness) 27% of our patients were identified as malnourished. These conclusions were confirmed in a larger series of 100 newly diagnosed patients from our own institution In the evaluation of the long term nutritional status of children with cancer and the identification of the incidence of malnutrition at diagnosis that a large number of patients (44%) were consuming considerably less energy than the recommended daily allowance for their age, and estimates of their own previous ‘normal’ intakes. Children with intra-abdominal solid tumours were more likely to be malnourished at diagnosis (35%) than those with leukaemia (2%) or extra- abdominal solid tumours (7%). It is evident that the presence of a large tumour load in a young child (with or without ascites or pleural effusion) could be responsible for their weight and weight for height, making this an unreliable index of nutritional status at diagnosis.


4 Lorber J. Freeze dried BCG vaccination of infants by the multiple puncture method. Tubercle 1959;40:2-5.

We agree that treatment itself is likely to be an important factor in subsequent nutritional progress and in our study the prevalence of malnutrition, identified by arm anthropometry, rose to 46% over a median follow up period of 7-5 months.

We conclude therefore that malnutrition in children with cancer is more common than generally recognised, particularly so at diagnosis, and that impaired energy intake is a factor in its causation. Further studies such as those by Bond and coworkers are required to explore the suggestion that changes in energy utilisation are also important, either at diagnosis or during treatment. Clinicians however must be aware of the greater incidence of malnutrition in these children and initiate appropriate strategies for nutritional support.

Of interest is the fact that 87 (35%) of our children had a history of learning disorder or had shown attention deficit, impulsiveness, or emotional behavioural problems before injury. This would support the authors' impression that many of their children did have pre-existing problems placing them at increased risk for injury.

The data from Scott-Jupp et al is interesting, but only a small number of children were followed up for a substantial time and the results must be interpreted with caution.

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Paediatrics in the accident and emergency department

Stir--I read the article by Phillips and Robson with interest. The writers say that the Speciality Advisory Committee requires only three months paediatric experience before accreditation as a consultant. In 1974 when a working party was set up to discuss the training programmes for consultants in charge of emergency departments and the possibility of planning a programme for senior registrars, paediatrics was listed as being 'a minor specialty' and it was with the greatest difficulty that I managed to persuade other members of the working party that it was so important that a specific requirement of time should be included.

I agree that three months is not enough but I can assure you that to achieve even that was a considerable victory.

I have felt for a long time that community paediatricians could play a most useful part in accident and emergency departments where children are seen but which are not part of a children's hospital. Appointments that are linked between the hospitals and the community are valuable at junior levels and can be even more so at senior ones.

A properly run paediatric accident and emergency department can save money for a hospital by reducing the numbers of children who are admitted. This can apply with many types of problems. One example among many, in Sheffield, is that of the about 200 children who are seen each year with acutely painful hips, the majority are dealt with without admission.

Many x ray films, drugs, and unnecessary investigations can be avoided with benefit both to the child and to the finances of the hospital. A lot of problems, medical, surgical and social, can be recognised at an early stage and treated.

More children are brought to accident and emergency departments than to all outpatient departments put together—they deserve a service that is appropriate to their needs and to the needs of their parents.

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Intravenous volume replacement: which fluid and why?

Stir---Lucinda Huskisson has done well in her outline of the continuing debate on which fluid to use during resuscitation.1 Doctors involved in the resuscitation of major trauma are now prescribing intravenous fluid, a modality of Advanced Trauma Life Support.2 This concentrates on the first hour after trauma—the 'golden hour'—and presents a standardised approach to the management of trauma. With regard to fluid replacement, Hartmann's solution and blood are the only two fluids advocated. In the child a regimen of three challenges of 20 ml of Hartmann's solution per kg is advised followed by 10 ml per kg of blood if the patient is still unstable. Continuing instability as judged by cardiac status, conscious level, skin perfusion, and urine output should prompt definitive operative care. Paediatricians who find themselves involved in resuscitation in the accident and emergency department should be aware of this protocol as it serves to keep arguments over crystalloids and colloids out of the resuscitation room—as Dr Huskisson demonstrates by her references that debate takes longer than a golden hour.

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Sister journals

Stir---David Mellor was undoubtedly right to criticise the English translations of the titles and abstracts of articles published in Archives Francaises de Pédiatrie.1 Some of them were certainly inaccurate and/or clumsy. We have taken his comments to heart and retained a biomedical translator. Let us hope that he will soon have no cause for such comments.

Dr Mellor cannot understand why there are many fewer original articles and clinical reports in Archives Francaises de Pédiatrie than in Archives of Disease in Childhood. There are two very simple explanations. First, French paediatricians publish their best work in English language, mainly American, journals. Curiously, the dominance of English in the scientific world has led clinicians and researchers wanting to be sure that their work is known to publish in English. This is exacerbated by the tendency of granting bodies in France to give a priority to such publications.2

Second, many of the subscribers to Archives Francaises de Pédiatrie are more interested in articles on new techniques, analyses, and applications than on review articles. This problem is not peculiar to French paediatrics; several other European journals have the same balance. The survival of our journal depends on the number of subscribers, and the more and more of them do not want articles that are too research oriented or that deal with very rare conditions. This may be unfortunate, but it is the case.

The French, in common with other Europeans, probably have less difficulty reading and writing English than the English have in
Malnutrition in children with cancer.

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Updated information and services can be found at:
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