LETTERS TO THE EDITOR

Response to venepuncture for monitoring in primary schools

EDITOR,—We welcome the commentaries that followed our paper that was published in May.1 We think, however, that we need to clarify some of the points made in these commentaries to represent the views of the team members.

The last sentence of our paper can be easily misinterpreted as conveying the idea that venepuncture is ethically acceptable if the scientific merit of the question is important and the methodology of the study is sound. We hope that the readers will be convinced after reading our paper that, in the conduct of the research question, that information was available to the children's parents in the study, that discomfort and the potential risks to the participants were minimal or negligible, and that parents and children were free to decide whether they wanted to participate in the study and free to withdraw from the study at any time, even after signing a consent form. The scientific merit of the research is an important criterion to consider in addition to honest information, minimal distress to participants, and freedom to withdraw from the study at any time.

Professor Cockburn's commentary may be interpreted as if we were challenging the Department of Health.2 We were aware of the recommendations of the Department of Health on local research ethics committees (1991)3 and the MRC document on the ethical conduct of research in children (1991).4 Neither document was available when we planned the pilot study and came to our attention after the pilot study was carried out in May 1992. In my judgment we did not contravene the MRC document because they explicitly include 'to obtain blood specimens' as an example of activities 'that may give rise to minimal or negligible risk to the participant' and it is worth commenting that for a long time we were reluctant to include venepuncture as part of our nutritional monitoring system. However, as the Department of Health was keen on the use of fasting or post-lunch blood samples, it was later decided to include venepuncture as a possible study procedure. It was always subject to the local ethics committee's agreement.

We were very critical of the decision of the BPA to classify venepuncture as a low risk procedure when we reviewed by Professor Hull's clarification that in experienced hands, venepuncture is a minimal risk procedure. One of our three phlebotomists had a very high rate of technical failures. We have learnt the lesson. For our main study we have made it clear to the venescors that they will have to spend some time training and the amount of training will be determined by the senior chief medical laboratory scientist of the department of haematology with whom we are collaborating.

Armed with the results of the pilot study we submitted a protocol to include venepuncture in our main study to ethics committees in England and Scotland. We were able to find that 25 out of the 26 ethics committees approved our request; one is still processing our application. Incidentally, only one of the ethics committees queried the gift of a T-shirt as a show of appreciation to the children and most of the headteachers collaborating with our study were supportive of this element of the study.

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Occtreotide treatment associated with adrenal suppression and poor feeding

EDITOR,—Occtreotide, a long acting somatostatin analogue, is increasingly used to stabilise children with hyperinsulinaemia before surgery, or even in long term control of hyperinsulinaemia.1 It has few reported side effects in this group of patients.2 We write to report probable association of the use of occtreotide with potentially severe adrenal suppression and with the less dangerous, but important problem of refusal of oral feeds.

Case report

A boy was born of consanguineous parents at 35 weeks' gestation weighing 1590 g. Hypoglycaemia was noted on the first day of life with increasing glucose utilisation to >12 mg/kg/minute. Investigations on day 8 revealed low free fatty acid and branch chain amino acid, normal growth hormone, and high insulin concentrations at the time of the hypoglycaemia. A diagnosis of hyperinsulinaemia was made and neodiosibiosis (pancreatic endocrine dysregulation syndrome), was confirmed on day 90 at 95% pancreatectomy resulting in subsequent normoglycaemia at six months' follow up.

Plasma cortisol was 56 nmol/l at the time of hypoglycaemia on day 9. The inadequate response was thought to be due to the immaturity of the infant. The long acting somatostatin analogue, octreotide, was commenced on day 10, 4.5 μg/kg/day along with physiological replacement doses of hydrocortisone. The predose 9 am plasma cortisol concentrations remained constantly low (56, 21, 56, 42, 14 nmol/l) until the time of surgery and cessation of octreotide and then rose to 494 nmol/l in 48 hours and remained normal subsequently.

The baby fed extremely poorly requiring nasogastric feeds till day 60 when a trial of diazoxide was commenced and the octreotide withdrawn. The baby fed well for eight days until diazoxide related heart failure supervened and octreotide was restarted at which point nasogastric feeds were once again required. Octreotide was withdrawn postoperatively and immediately the child again took oral feeds.

The feeding difficulties and suppressed plasma cortisol concentrations in this child seem related to octreotide treatment. Somatostatin suppresses many peptide hormones and has a well established use in nesodiosibiosis, sometimes for long periods with few reported side effects.3 Its use has been explored in putputatory Cushing's syndrome with varying success.2,4 Suppression of appetite has been reported in a Committee on Safety of Medicines in one previous adult case but there have been no previous reports of hypoprotocortisolaemia.

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Aetiology of childhood leukaemia

EDITOR,—The review by Taylor on immunogenetics and the aetiology of childhood leukaemia,1 refers to the possible role of environmental factors, including infection, on the incidence of this disease. The observation that the mortality rate due to leukaemia rose 4-5% annually in Great Britain between 1911 and 1959 is cited.2 Interestingly, 1911 is the year in which the threat of tuberculous cattle to human health was first recognised in the British Royal Commission on Tuberculosis. This led to an increased use of preventive measures, initially pasteurisation of milk and subsequently eradication of infected cattle. Before that time, infection of human beings by the bovine tubercle bacillus (Mycobacterium bovis) was a common event but most infections resolved spontaneously and appeared to afford protection against pulmonary tuberculosis of human origin later in life. Accordingly BCG vaccine, produced from M bovis and originally given orally to neonates, was intended to mimic this natural milk borne infection.

Some authors have claimed that BCG vaccination leads to a reduction in the incidence of leukaemias and other childhood cancers though others refute these claims. A re-evaluation of these reports revealed that BCG showed a significant protective effect only when it was given neonatally and in regions where protection against tuberculosis was also demonstrable.3 One explanation of this claimed effect is that BCG vaccination enhances the ability of cell mediated immune responses to remove any leukaemic cells from which cancers might otherwise arise.4 It is therefore possible that natural infection by M bovis or its artificial analogue, BCG vaccination, in infancy might afford protection against childhood leukaemia. This hypothesis could be tested in regions or countries that are undergoing changes in BCG vaccination policies.

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Cough Brown Rosenthal am Grange data about episodes matched immunisation significant adult childhood that childhood expense little long bearing however, the marked reduced from childhood acute lymphoblastic leukaemia1 and more recent studies failed to indicate any significant benefit of BCG immunotherapy. In adult myeloid leukaemia combined BCG/allogeneic immunotherapy stimulated strong cell mediated immunity to donor, but not to autologous leukaemia cells,2 and produced little long term benefit. The use and expense of prophylactic BCG vaccination as an immunological protective measure in childhood leukaemia would only be justified if it markedly reduced the incidence of the disease. Positive preliminary evidence from the UKCSS might justify a detailed prospective control study in the UK. However, bearing in mind Greaves’ hypothesis that childhood leukaemia could arise from inappropriate immunostimulation,3 there is much to commend a cautious and considered approach to the use of prophylactic BCG vaccination as a preventative measure in childhood leukaemia.


Cough – but is it asthma?

EDITOR—Dr Sheila McKenzie has suggested that cough without wheeze should not be classified as asthma unless there is evidence of airway lability:1 otherwise, chronic cough is most troublesome in preschool children who cannot reliably perform standard tests of lung function. A study of 60 children under 6 years with chronic cough showed that 63% produced at least one positive reaction to skin testing with inhaled allergens (57% for house dust mite) compared with 75% of children with classical asthma and 10% of children without respiratory problems.2 Chronic cough, like wheeze, was usually worse at night (75%), precipitated by exercise (85%), and associated with nasal discharge (70%) or sore throat (32%). Studies of children reported improvement or no cough at all but 25% developed recurrent wheeze as well as cough. It was difficult to assess response of cough to treatment because of the tendency to spontaneous resolution. Cough alone may just be a feature of the viral upper respiratory infection which can also induce wheeze in asthmatic children or it may be a manifestation of airway inflammation triggered by hypersensitivity to inhaled allergens such as house dust mite. Although most children with chronic cough do not have asthma, there is no reliable way of identifying those who eventually develop bronchospasm. For persistent cough a trial of inhaled β agonists or inhaled steroids is logical and potentially less harmful than other common remedies such as antibiotics, or even surgical ear, nose, and throat procedures.

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Growth standards for infancy

EDITOR—We fully endorse the views of Wright et al on the need to develop new growth standards for infancy.3 The comparison of their Newcastle data with widely used standards4 and with the Cambridge Infant Growth Study5 illustrates this need succinctly. The Cambridge study is not, however, confined to breast fed infants. Although a high proportion (90%) were initially breast fed,3 this declined to 65% by 12 weeks, 54% by 24 weeks, and 18% by 1 year. Throughout most of the first year, the weights of infants breast fed to at least 24 weeks were similar to those breast fed from 3 weeks onwards. Both groups showed an increased weight gain compared with standards in the first six months, followed by a more marked relative decline, with only the breast fed boys showing a slight slower growth rate in the second months compared with those bottle fed. At 1 year, the mean (SD) weights were: boys breast fed (n=54) 9.79 (0.93) kg, bottle fed (n=35) 9.93 (0.97) kg, girls breast fed (n=59) 9.17 (0.84) kg, bottle fed (n=84) 9.18 (0.80) kg, and the Z scores6 were −0.4, −0.2, −0.5, and −0.6 respectively. Weaning practices are at least as important as mode of milk feeding. Energy intakes during and after weaning are lower now than in the 1950s when the standards were prepared.4 In view of the differences in feeding practices and social circumstances, it is encouraging to find that the growth of Cambridge infants showed such similarities to the Newcastle data.

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Any book which, in the opening few sentences, can give a name check to Hippocrates, Descartes and Freud, is clearly not going to come with a blank slate. Of more importance is whether it can perform equally well or better in the areas of elucidation and education.

Happily for the reader, the answer is a resounding yes. This book addresses, both clearly and highly informatively, major developments in the psychological treatments of psychosomatic and physical disorders.

The stimulus for this book was provided through both the diversity of its approaches and the back book that the book is, both authentic and as a whole and does not suffer the disconnectedness of some texts derived from conferences rather than de novo.

The book is divided into two sections. In the first, there is an overview of psychoanalytic, cognitive behavioural, and family psychotherapy approaches in dealing with psychosomatic and physical disorders. The second section looks at the application of these approaches to particular conditions such as somatisation disorder, irritable bowel syndrome, chronic pain, brittle diabetes, and anorexia nervosa.

The major strengths of the book are its comprehensive coverage of both theory and practice, and its ability to bring the two together harmoniously.

Theoretically, there are good outlines of the ideas behind the different therapeutic approaches. Particularly strong is Tom Sensky’s description of cognitive therapy, succinctly covering the important aspects of the cognitive model (including dysfunctional beliefs, negative automatic thoughts, and cognitive distortions), and its therapeutic approaches. He makes the important point that especially in physical illness, not all false beliefs are dysfunctional and not all dysfunctional beliefs are false. For example, denying the seriousness of illness when its presence can sometimes serve as a protective function and is therefore not necessarily dysfunctional. Conversely, the belief of ‘not having long enough to live to achieve what I want’ might be true but might also be dysfunctional if it results in the ill person focusing on nothing other than this belief and giving up trying to achieve anything. Dr Sensky stresses that the focus of therapeutic work in cognitive therapy is to focus on dysfunctional beliefs, not to...
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