LETTERS TO THE EDITOR

Fragile X syndrome

EDITOR,—Our experience in a special school in Newcastle upon Tyne lends support to the proposal by Slaney et al to screen for fragile X syndrome.1 Many individuals with special educational needs have not had recent investigation. In a preliminary survey of 90 children of the year 1992/3, of the 58 individuals (44 male and 14 female) who had statutory reassessment of special educational needs in Newcastle upon Tyne, 48 were considered to have mild learning difficulties, 10 severe. All those having severe learning difficulties had been fully investigated by this stage. Among those with mild learning difficulties, one individual, known to have fragile X syndrome but in 41/48 there was neither known diagnosis nor record of genetic investigations. Over half of these children, 21/41, had a family history of learning difficulties.

On the basis of these findings, chromosome analysis and molecular investigations for the fragile X syndrome was offered at one special school as a part of the medical review undertaken for the statutory reassessment of special educational needs during the period September 1993—July 1994. None of the 34 children, aged 13—14 years, had a recognised diagnosis, although two had had previous genetic testing. There were 32 individuals with no known diagnosis to whom testing was offered, after full discussion of the details and implications of such investigations with each family. Blood samples were obtained from three girls and 23 boys: the remaining six pupils declined testing on account of fear of venepuncture. One boy with fragile X syndrome, one boy with Klinefelter’s syndrome 47,XXY, and one chromosomal deletion 46,XXY (case 8) were detected. A satellite Y chromosome was observed in one boy, which was thought to be a normal variant.

The families were referred for specialist genetic counselling. In the three cases where a diagnosis was given, parents were relieved to have an explanation for their child’s learning difficulty. Liaison with educational and community provision was facilitated. Thus, in three out of 26 children, testing of a previously unrecognised diagnosis was made. Not only did we detect previously unrecognised fragile X syndrome but, with the inclusion of cyto-genetic analysis as recommended in screening of populations selected on the basis of learning difficulties (unlike the restricted study by Slaney et al), also detected other important abnormalities. In their study, counselling was retrospective. In practice, we found that the opportunity to counsel families before testing could easily assimilated by a school doctor within the procedure required for medical input associated with the Education Act 1981, when parental concerns about the aetiology and implications of their child’s problems often need to be readdressed. We believe that the offer of genetic screening in this way is feasible, within both the existing community health and regional genetic service resources, and welcomed by those involved.

The findings of our study would support an argument to retain medical input, since the ‘transitional review’ (Education Act 1993) of children who have statements of special educational needs, at least until the cohort of younger children, who are more likely to have been investigated, is reached.

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Do children with hepatic cirrhosis complicating cystic fibrosis receive too much pancreatic enzyme?

EDITOR,—Colonic strictures1 and thickening of the bowel2 have recently been recognised in children with cystic fibrosis receiving high doses of pancreatic enzymes. We are concerned that some children with the complication of hepatic cirrhosis in cystic fibrosis are receiving excessive doses of pancreatic enzyme supplements in an attempt to control their steatorrhoea.

In the past 4—5 years we have assessed 13 children with cystic fibrosis complicated by hepatic cirrhosis for liver transplantation. Twelve were malnourished with median body mass index 16.5 (range 13.4—23.3) and upper arm circumference measurements all under the 5th centile. Seven gave a history of steatorrhoea and six required regular laxatives to prevent distal intestinal obstruction. There was wide variation in the daily intake of pancreatic enzymes (table), but the mean for the group was 16 653 units/kg/day of lipase and 544 units/kg/day of protease. In a recent study Sweeney et al found that a daily protease intake of more than 265 units/kg may be a risk factor for bowel wall thickening and that the risk rose 10 times if laxatives were taken in conjunction.3 Six of the children we report here had high daily intakes of protease (410—3688 units/kg/day), five received high strength pancreatic enzyme preparations, and three of these also required regular laxatives.

We did not assess the bowel wall thickness in these children, but, when investigated for abdominal pain by abdominal computed tomography, patient 6 was found to have 3 mm thickening of the walls of both the small and large intestine. Patient 5 developed a haemorrhagic colitis which resolved when his pancreatic enzyme intake was reduced. Both these patients had received high strength enzyme preparations.

Nine of these children have now received liver grafts and their daily enzyme intake is greatly reduced (table). The average daily protease intake has fallen by 56% and the daily lipase intake by 61%. In spite of this reduction in pancreatic enzyme dose absorption has improved and none of the children now have steatorrhoea. All except one now receive normal strength pancreatic enzyme preparations.

In children with cystic fibrosis and hepatic cirrhosis steatorrhoea may be a symptom of both the hepatic disease and pancreatic insufficiency. There is little benefit to be gained from increasing the enzyme doses above the recommended amounts of 265 units/kg/day of protease3 and doing so may be associated with considerable risk of gut complications.

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Monoclonal IgA gammopathy in a well infant

EDITOR,—We report on an unusual case of monoclonal gammopathy in an infant with no evidence of an underlying disorder. A 15 month old girl was referred because of raised serum IgA concentration (3—50 g/l) and IgA paraprotein. The indication for the investigation had been recurrent upper respiratory tract infections: five to six per year since attendance at day school. Her perinatal and previous medical history were unremarkable, with no suggestion of immunodeficiency, serious infections, or malignant disorder.

Her physical examination was normal (weight: 25th centile, height: 50th centile). On follow up at 20 months she had remained well and had developed varicella at 19 months with no complications, suggestive of intact T cell function.

The IgA paraprotein was confirmed at 18 and 20 months by serum electrophoresis and immunofixation of the a and lam chains (1—2 g/l on both occasions). Investigations showed a haemoglobin concentration of 120 g/l, white

Details of children studied

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<td>Steatorrhoea</td>
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<tr>
<td>Mean</td>
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cell count 8.6 × 10^6/l, serum IgA 3.15 g/l (18 months) and 2.65 g/l (20 months), antinuclear antibody titre 1:80. There was no IgG or IgM to Epstein-Barr virus, cytomegalovirus, or human herpesvirus type 6. Light chains, a normal number and proportion of T and B cells, and normal whole blood proliferation to mitogen. Chest radiography and abdominal ultrasound were normal.

The pathogenesis of the paraprotein in our patient is unclear. The adult entity of benign monoclonal gammopathy has not been described in the paediatric population, and previous reports of monoclonal gammopathy in children have consistently associated such gammopathies with serious disease. Additionally, there are no reports of a monoclonal gammopathy as an incidental finding in an otherwise healthy child. In a 10 year review of 4000 highly selected children, 155 (3.9%) were found to have paraproteinaemia.1 These children were suffering from primary and secondary immunodeficiency, malignancy, autoimmune disease, asthma, serious infection, and asplenia. In contrast, none of the 120 healthy paediatric controls used in this study (donors for bone marrow transplantations) identified paraproteins.

Our case is also unusual in that her paraprotein is of the IgA type, as there are only four reports of IgA monoclonal gammopathy in the paediatric population. Two of these children had a severe combined immunodeficiency,1 one had an unspecified malignancy,2 and the other an unspecified chromosomal disorder.3 Of the 155 children with monoclonal gammopathy in the 10 year study previously referred to, no IgA paraproteins were identified.

It is possible this abnormal production of IgA is related to a subtle T cell dysregulation. Such dyshomeostasis of T cells has been implicated in another paediatric disorder associated with raised IgA, IgA nephropathy. In this condition abnormal T cell function and signalling is thought to be responsible for the aberrant B cell activity, where respiratory pathogens or common environmental antigens stimulate excessive production of IgA, in the presence of increased helper T cell activity and decreased suppression of T cell numbers.8

We are following up this infant, with much interest, for any alteration in her IgA paraprotein or immune function, and for the possible development of disease.

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Long term follow up to determine the progression of imaging after urinary tract infections

Editor—We read with interest the two papers by Merrick et al on the prognostic value of imaging in children with urinary tract infections (UTIs).1 2

It would be helpful if the authors could tell us what proportion of the initial cohort of children with UTI, during 1975 to 1990, underwent initial imaging and, if so, follow up imaging. We have shown that in an area of very good standard for general practice only a small minority of children with UTI had been referred for radiological investigations.3 The fact that this ‘denominator’ figure is not provided casts doubts on how representative their results are. The true natural history and prognostic value of different radiological abnormalities such as UTI cystitis, can only be determined on a large scale, prospective, hospital and community based study.

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Dr Utlley comments:

I would like to thank Dr Jadresic for her interest in the two papers by Merrick et al.4 It is true that there were no Edinburgh hospitals with UTI, either acutely or after treatment, would have undergone imaging of their urinary tract in some form. This has been standard hospital practice and has occurred teaching throughout the period of the review. Indeed the need for investigation after a single UTI has been the formal recommendation to undergraduates, postgraduates, and general practitioners throughout. Needless to say we have no information regarding children not referred by their general practitioners and we agree with Dr Jadresic that some patients may not have been referred. Large scale prospective studies are clearly required, and indeed the recommendation has been standard hospital practice and would still be well received. However, we do feel the indirect voiding study to be a more sensitive, and a substantially less invasive and traumatic way of assessing the presence or absence of VUR in all children who have achieved bladder control and that this now should be seen as the initial test for reflux.

The data presented reaffirm the importance of reflex as a risk factor for progressive renal damage generally and particularly so when associated with infection.

The fact that VUR did not come out as a risk factor for progressive renal damage in boys under 1 year of age, the authors excluded bladders with a small neck on VUR would indeed be well received. However, we do feel the indirect voiding study to be a more sensitive, and a substantially less invasive and traumatic way of assessing the presence or absence of VUR in all children who have achieved bladder control and that this now should be seen as the initial test for reflex.

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With regard to the letter of Drs Robson and Kelley we do not recommend MCU to be restricted solely to females who have not achieved bladder control. Although it has not emerged as an independent variable for progression of renal disease in young boys, an MCU is clearly an important part of their work-up, particularly after febrile UTI and we therefore would like to see this noted. We also feel that further studies a more child friendly version of the test is required. Indeed the need for appropriate antibiotic prophylaxis is clear and the presence of VUR would well be noted. However, we do feel the indirect voiding study to be a more sensitive, and a substantially less invasive and traumatic way of assessing the presence or absence of VUR in all children who have achieved bladder control and that this now should be seen as the initial test for reflux.

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