Prevalence of antidelta in Turkish children with chronic hepatitis B infection

Delta hepatitis is caused by a dual infection with the hepatitis delta virus (HDV) and hepatitis B virus (HBV). HDV depends on the helper function of hepatitis B surface antigen (HBsAg) for its replication. Therefore, epidemiology of delta hepatitis usually follows that of HBV infection and it is particularly prevalent in endemic areas for HBV infection. The incidence of anti-HDV positivity appears to increase with age, especially among anti-HBe positive carriers.1

Infection with HDV occurs either as coinfection with the HBV or as superinfection in a chronic HBV carrier. Although it is often associated with chronic and progressive liver disease, the natural course may vary.2

To establish the prevalence of delta infection in children, we investigated total anti-delta using an ELISA system (Organon Technica) in 206 children who were chronically infected with HBV (121 asymptomatic carriers, 59 with chronic persistent hepatitis, 13 with chronic active hepatitis, and 13 with cirrhosis) aged between 8 months and 17 years (mean SD) 7.76 (3.70) years. We detected antidelta in only six patients (2.95%): in three with cirrhosis, two with chronic active hepatitis, and one with chronic persistent hepatitis. The ages ranged between 8 and 13 years. Four of them were positive for serum HBsAg and two were positive for anti-HBe. None of the asymptomatic carriers had antidelta. When we take into consideration the prevalence of antidelta in children with chronic liver disease it was 7.1% (six of 85 children with chronic hepatitis or cirrhosis). During four to seven years of follow up clinical and laboratory findings of our patients remained stable.

Turkey has an intermediate endemicity for HBV infection and the prevalence of HBsAg carriers varies from 4% to 10%1,2 and antidelta positivity in adult patients with chronic hepatitis B has been found up to 36% in prevalence studies.3 Farci et al, in Italy, found a prevalence of 12.5% of antidelta in chronic hepatitis B infected children.4 However, in their study all children had chronic liver disease. The prevalence of antidelta in Turkish children is lower than that in Italian children, even if we consider only the patients with chronic hepatitis or cirrhosis (7.1% v 12.5%, respectively). There was no difference in the mean age of the patients and in the follow up duration between two studies. In Egypt a low prevalence of antidelta in children was reported (4.2%),5 whereas Ruiz-Moreno et al found a high prevalence in Spain (13%).6 The prevalence of antidelta in adults in Italy7 is similar to our country. The route of transmission of HDV infection in children might be different in various countries. The percentage of delta infection parallels the severity of the disease;1 in our study antidelta positivity was also high in patients with chronic active hepatitis (2/13), while none of asymptomatic carriers had antidelta. As previously shown in children and adults,1 a correlation between chronic delta infection and presence of anti-HBe was not observed in our patients. Although it was believed that delta infection usually worsened the course of the disease, clinical and laboratory findings of our patients were stable over time, similar to that found in the study of Bortolotti et al.2

We conclude that in our country the prevalence of HDV infection is not high during childhood, and it decreases with age suggesting that HDV infection is usually acquired as a superinfection rather than coinfection and vertical transmission is uncommon. The course of the disease is usually stable. The epidemiology of HDV infection is different in various countries. To explain the differences in geographical distribution of HDV infection further studies are needed.

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Misdiagnosis of pancreatitis during valproate treatment in gastro-oesophageal reflux

Pancreatitis should always be suspected in patients with severe gastrointestinal symptoms during sodium valproate treatment. We report a child, receiving sodium valproate, in whom we misdiagnosed pancreatitis because of high serum amylasies, which were later shown to be mainly of salivary origin (90%). We believe that a combination of gastro-oesophageal reflux plus the use of crushable sodium valproate (rather than enteric coated) led to ulcerative oesophagitis and absorption of laminar fluid with pancreatic sequelae.

A 16 year old, severely retarded child was admitted to the hospital because his epilepsy worsened. Ten days later the boy was reported to be having fits of a new type: electroshock-like jerks, sweating, and hyperventilation provoked by turning the body, washing, and feeding. Feeding became difficult because of frequent attacks and associated delirium. He also had convulsions.

He was suspected of having pancreatitis caused by his sodium valproate treatment. Serum amylasies rose rapidly to 3000 (normal 70-300) U/L. Valproate treatment was discontinued. Parental fluids were given for four weeks and as a complication of this subclinical catheter he acquired bacterial sepsis and candida infection. Oesophagography showed haemorrhagic ulceration, mediastinal oedema and gastro-oesophageal reflux. Surprisingly, 90% of the total serum amylase was of salivary origin and 10% of pancreatic origin. As he did not have pancreatitis, valproate was restarted, but now as enteric coated tablets. After revision of the subclavian catheter, and some days after starting antibiotics, he became afebrile and sepsis abated. His convulsions, both the original type and his new ‘fits’, became infrequent, and he was discharged.

His grandparents indicated that at home he was fed in a sitting position and the valproate was given as enteric coated tablets, whereas in hospital he was fed in a semi-recumbent position and crushable valproate tablets were used. The valproate, which is acid, was probably rapidly absorbed, and was locally irritating to the stomach and oesophagus. It may be that in these conditions, luminal amylase, which normally does not cross the gastric or intestinal mucosa, enters the blood or lymphatics.

Vasculitis associated with levetiracetam and circulating autoantibodies

Levetiracetam is used in relapsing nephrotic syndrome or as an adjuvant treatment to sur- gency in cold agglutinins.1 Three cutaneous vasculitides have been reported in adults on levetiracetam.2-4 No information is available on circulating autoantibodies in this condition.

We would like to report a girl who had steroid dependent minimal change idiopathic nephrotic syndrome since the age of 6 years. The disease course was positively influenced by long term medication with levetiracetam and prednisone. Levetiracetam was stopped on two occasions but had to be resumed because of nephrotic relapses. At the age of 11.5 years, while continuing treatment with levetiracetam 1.2 mg/kg daily and prednison 0.06 mg/kg every second day, the girl developed fever, arthralgia, and a non-palpable purpuric rash with a livedo pattern, chiefly on the breast, face, and arms. Physical and laboratory investigations failed to show signs consistent with systemic involvement. Circulating for per nuclear antineutrophil cytoplasmic autoantibodies (titre 1:2560) were detectable by indirect immunofluorescence on ethanol fixed granulocytes and a characteristic cytoplastic reaction was obtained on formalin fixed nuclei. However, at most only border-
There are several excellent alternative teaching aids I prefer: *ABC of Child Abuse* (edited by S R Meadows; London; BMJ Publications, 1989) (this includes the work of the authors of this atlas), *Atlas of Child Sexual Abuse* (edited by D Chadwick et al); Chicago: Yearbook Publications, 1989 (a masterly monograph), *The Butcher Child* (by S M Smith); London: Butterworth, 1975 (which in 27 illustrations shows most aspects of physical abuse and has a useful historical introduction). *Child Perinatal Forensics* (edited by I Blumenthal); London: Edward Arnold, 1994 (uses line drawings rather than photographs in a balanced comprehensive text). *Clinical Perinatal Forensic Investigation* (by D Chadwick); London: Pinter Publications, 1990 (the chapters on child abuse and child sexual abuse have clear uncontroversial text with line illustrations).

Sadly, I cannot recommend this beautifully produced atlas because of its poor organisation, lack of index, ambiguous text, and lack of differential diagnoses. It serves as a useful record of the work and opinions of two pioneering paediatricians.

**R SUNDERLAND**
Consultant paediatrician


David Hall and Peter Hill offer this book to hospital paediatricians and general practitioners working in all disciplines and to non-medical disciplines but curiously do not mention community paediatricians specifically as a target audience. It assumes previous knowledge of paediatrics and is clearly not an introductory text. Polnay and Hall's *Community Paediatrics* is therefore a better buy for undergraduates or the senior house officer entering the world outside hospital for the first time. But this book undoubtedly fills a gap in the market for specialist registrars embarking on the more specialised aspects of developmental assessment in a community setting or the child development centre. Until now such skills have had to be learnt by word of mouth backed up where possible with in-house teaching materials. The advent of a core text will be a blessing to those of us involved in specialist training.

The first seven chapters address in detail the assessment of children referred with developmental delay and the management of disclosure of developmental problems. The layout is pleasing to the eye, having two columns per page, with lots of headings. There are numerous tables giving useful hints on how to approach initial interviews and how to extract useful information by appropriately phrased questions (all illustrated and outlined in the tables). The review of normal development is useful and hearing and vision assessment is described separately. Tests used in the assessment of intelligence, speech, and language and general health are reviewed and their limitations and uses discussed. Headings will allow readers to dip into the text but the book is also eminently readable chapter by chapter.

The rest of the book is devoted to specific developmental disorders including their clinical features, investigation, and long term management. The choice of conditions described in detail is satisfactory with half a page on the genetic variants of physical signs and symptoms.
Vasculitis associated with levamisole and circulating autoantibodies.

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