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child with a squint that is not cosmetically noticeable, unless visual acuity is checked earlier than school entry. Assessment of function in each area of development is surely basic to developmental assessment?

References

- 1 Illingworth R S. Letter: A suggested child-health clinic form. *Arch Dis Child* 1980; **55**: 163.
- 2 Cooper J, Moodley M, Reynell J. Intervention programmes for preschool children with delayed language development. A preliminary report. *Br J Disord Commun* 1974; **9**: 81-91.
- 3 Cooper J, Moodley M, Reynell J. The developmental language programme. Results from a five year study. *Br J Disord Commun* 1979; **14**: 57-69.
- 4 Sonksen P M. The assessment needs of preschool children with handicaps of language development. *Child Care Health Dev* 1977; **3**: 319-23.
- 5 Ingram R M. The problem of screening children for visual defects. *Br J Ophthalmol* 1977; **61**: 4-7.
- 6 Cooper J, Moodley M, Reynell J. *Helping language development*. London: Arnold, 1978.

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Human growth hormone (UK)

Sir,

A paragraph in the Annotation by Milner¹ has been interpreted by some of my professional colleagues as meaning that I have acted in breach of Rule 15, paragraph 3 of the *Rules of the BPA* and been guilty of unprofessional conduct. The collocation on p.734 of a quotation from my address to the annual meeting of the BPA on 28 March 1979, and the immediately succeeding sentence: 'The next day... poor growth youngsters' coupled with Rule 15, paragraph 3 of the *Rules of the BPA* clearly implies that I communicated my views to the *Glasgow Herald*, or was a party to the *Glasgow Herald* publishing its article.

The facts are that I have for some time been treating patients at the Royal Hospital for Sick Children, Glasgow, for growth hormone deficiency with hGH (UK). Recently I became disturbed about the possibility of contaminants in the hGH (UK) adversely affecting some of these patients. I therefore invited the parents of all my patients to come to the hospital and explained to them that I had become aware of the overall nature of the preparation in use and that from my search of the literature I could not find an irrefragable statement that the contaminants had no deleterious effects on children. I made the point that it was right and proper that parents should be aware of the facts. I understand that a parent of one patient communicated with the press.

At the meeting in York I observed a newspaper reporter, for whose presence I was not responsible. This

reporter had approached me some time previously but I declined to make any statement. The articles in the *Glasgow Herald* of 29 March headed:

'Scots doctor challenges growth treatment': HGH 'Wonder cure' has turned sour for our 'poor growth' youngsters: Why are the doctors staying tight lipped?: Fearful parents who stopped hormone therapy on daughter: Medical treatment for one child that can cost a cool £40 000

were neither written nor authorised by me, nor was any matter on the subject communicated to the *Glasgow Herald* or any of its staff either by me or on my behalf, at this time.

The facts accordingly do not justify the inference naturally drawn by some of my colleagues from the collocation of the sentences on p. 734 of the *Archives*.

In these circumstances I must request you to publish this explanation and to make a suitable correction and sufficient apology to me for the imputation against my professional character.

Reference

- 1 Milner R D G. Human growth hormone (UK). *Arch Dis Child* 1979; **54**: 733-4.

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The Editors comment:

Neither the editors nor Dr Milner intended to imply that Dr Hamilton was responsible for the reports in the *Glasgow Herald*, or that he had committed any kind of professional misconduct. We are happy to make this entirely clear and to publish Dr Hamilton's explanation.

Upper urinary tract anomalies in the congenital adrenogenital syndrome

Sir,

McMillan *et al.*¹ noted there is often an association between congenital adrenal hyperplasia and anomalies of the upper urinary tract. We studied 13 patients with congenital adrenal hyperplasia diagnosed by conventional methods to see if such an association exists. The ages of the patients ranged from 1 month to 8 years. 12 of them (7 boys and 5 girls) had a deficiency of 21-hydroxylase, 10 being 'salt losers'. The 13th was diagnosed as having a deficiency of 11-beta-hydroxylase; she was hypertensive. The 17-ketosteroids in 24-hour urine collections were raised in all patients, with a wide range of values from 3.0 to 9.2 mg/24 h (10.4 to 31.9 μ mol/24 h), well above those found in normal children. Excretion of pregnanetriol in the urine was raised in 12 patients (in one it could not be determined). In all patients intravenous pyelography was performed; only one, in a male 'salt loser' with