Short reports

Premature menarche: a follow-up study

D MURRAM, JOHN DEWHURST, AND D B GRANT

The Hospital for Sick Children, London

SUMMARY Follow-up information was obtained from 12 women aged 16-34 years who had been seen previously because of premature isolated menstrual bleeding (premature menarche) starting between ages 9 months and 9 years. All the women reported normal regular menses and fertility was normal in the 6 women who had married.

Cyclic vaginal bleeding in the absence of other signs of secondary sexual development was described in 4 girls by Heller *et al.*¹ and given the name of premature menarche. Twelve other patients are described in whom a similar pattern of recurrent vaginal bleeding was present in the absence of secondary sexual development. Their subsequent menstrual and obstetric histories are documented.

Patients and methods

We have reviewed the medical records of 12 girls who were first seen at this hospital between 1951 and 1972 because of recurrent vaginal bleeding in the absence of other signs of puberty. The current ages of these patients range from 16 to 34 years. As they no longer attend the hospital clinic, information on their current menstrual pattern and obstetric histories was obtained by asking them to complete a

short questionnaire. In each case this approach was made in agreement with the family doctor.

Results

In the Table various clinical details relating to these 12 patients are given. The age of onset of vaginal bleeding varied between 9 months and 9 years. The duration of the regular bleeding was similarly variable, between 1 and 6 years. In each case bleeding had stopped by age 10 years and had restarted between 3 and 11 years later, after the appearance of other signs of secondary sexual development as part of an apparently normal pattern of adolescent development.

All patients now have regular menstrual periods which became re-established between ages 10 and 14½ years (Table). Six of the patients are married and have conceived 10 pregnancies without difficulty. One patient is currently pregnant and the remaining 9 pregnancies resulted in 8 live children and one abortion.

Ten of the 12 patients gave their current height. Since this varied between 153 and 173 cm (10th-95th centiles), it seems reasonable to suppose that stature is little, if any, affected by premature menarche.

All patients in this series had initially been investigated by methods that were considered

Table Clinical details of the 12 patients

Case	Age (years)			Menstrual pattern	Marital and fertility status
	Present	During cyclic vaginal bleeding	At 'normal' menarche		
1	34	9/12-7½	10½	Regular monthly	Married, 3 children
2	31	7-8½	12	Regular monthly	Married, 1 child
3	30	7-8	13	Regular monthly	Married, 1 child
4	28	3-5	11	Regular monthly	Married, 2 children
5	27	6-8	14	Regular monthly	Married, now pregnant
6	24	8-9	13	Regular monthly	Married, 1 child, 1 abortion
7	24	9-10	13	Regular monthly	Single
8	24	9-10	14½	Regular monthly	Single
9	23	4-6	10	Regular monthly	Single
10	23	7-9	12	Regular monthly	Single
11	22	2-4½	11	Regular monthly	Single
12	16	2-5½	12	Regular monthly	Single

appropriate at the time. No important general disease had been discovered. Similarly all patients had been examined under anaesthesia and no evidence of a local cause for the bleeding had been found.

Discussion

It is evident from the information set out in the Table and that contained in the previous report by Heller *et al.*¹ that the disorder of premature menarche is a transient one although the duration of the premature bleeding may be several years. It is reassuring to know that normal pubertal development with the resumption of menstruation occurs at an appropriate age and has no effect on the subsequent fertility of the patient. It is reassuring, too, to realise that the disorder of premature menarche does not appear to result in any limitation of the final height of the patient, so there need be no concern over short stature, unlike the case with other forms of sexual precocity.

We believe that the diagnosis of premature menarche can be strongly suspected on clinical

grounds on the basis of recurrent vaginal bleeding in the absence of other signs of secondary sexual development; however, we believe it important to exclude the presence of a local lesion of the genital tract by examination under anaesthesia or by sonography, or both. It must be remembered that when the first episode of bleeding occurs there is no indication that it will be recurrent, so the possibility of an intravaginal neoplasm must be excluded. Once other investigations have excluded the presence of an intracranial lesion which might be presenting in this unusual fashion, treatment is probably not indicated, since the disorder appears to be self limiting and has no long-term effect on the patient's menstrual pattern or fertility.

Reference

- ¹ Heller M E, Dewhurst John, Grant D B. Premature menarche without other evidence of precocious puberty. *Arch Dis Child* 1979; **54**: 472-5.

Correspondence to Dr D B Grant, The Hospital for Sick Children, Great Ormond Street, London WC1N 1JH.

Received 29 September 1982

Infection in neonatal hypothermia

A S EL-RADHI, M H JAWAD, N MANSOR, M IBRAHIM, AND I I JAMIL

Children's Hospital in Al-Thawra, Al-Thawra, Baghdad, Iraq

SUMMARY Infection, particularly of the respiratory tract, was present in 80 of 138 children with neonatal hypothermia. The most common lesion was right upper lobe atelectasis and was probably due to aspiration pneumonia. In children older than 3 days infection elsewhere, mainly owing to *Escherichia coli* bacilli, was common.

Hypothermia in tropical and subtropical areas is a major cause of infant mortality.¹ Neonatal hypothermia, often with classical cold injury,² is common in Baghdad, and the neonatal death rate related to hypothermia is second only to that of respiratory infection during the winter.

Previous reports on hypothermia in developed countries³⁻⁴ and in developing ones⁵ have not stressed the role of infection. We present an analysis of 138 children admitted to our hospital with hypothermia.

Patients and methods

During the winters of 1978-79 and 1979-80, 138

newborn infants with hypothermia (rectal temperature below 35°C) admitted to this hospital were studied.

Al-Thawrah district is one of the poorest areas of the city. Details of the infants are shown in Table 1. There were 82 boys and 56 girls aged between 1 day and 4 weeks. Twenty-seven were younger than 4 days (early-onset hypothermia). As nearly all children are born at home, the birthweight is not known. On arrival to the hospital 79 weighed less than 2.5 kg, and probably had low birthweight. The 138 patients were investigated as follows: (1) Blood culture. (2) Urine chemistry, microscopical examination, and culture. (3) Cerebrospinal fluid chemistry, microscopical examination, and culture. (4) Chest x-ray film.

With the exception of 2 patients, all those with late-onset hypothermia (older than 3 days) were treated with intramuscular gentamicin in a dose of 4-6 mg/kg a day. The 2 children had osteomyelitis and were given cloxacillin 100 mg/kg a day. Only 3 children with early-onset hypothermia were treated with antibiotics, 2 with penicillin because of infection