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Tracing malformation syndromes with MEDLINE

Sir,

A recent annotation by Winter and Baraitser¹ reported their difficulties in finding recently published descriptions of malformation syndromes in *Index Medicus*. They went on to discuss the use of computers in recording and searching for combinations of abnormalities, but failed to mention the use of MEDLINE (the online version of *Index Medicus*) which is widely available and suitable for this purpose.

MEDLINE uses a fixed vocabulary of indexing headings—medical subject headings and subheadings. It also has the capability of searching for textwords or phrases in the titles of articles and in the author abstracts, and can be used to retrieve combinations of any or all of these elements.²

Many of the more common syndromes and malformations are available as medical subject headings: for example, *Down's syndrome*, *Fetal alcohol syndrome*, *Noonan syndrome*, and *Anus, imperforate*. Other syndromes are indexed as combinations of medical subject headings, for example, *Williams-Campbell syndrome* under the combination *Bronchiectasis+bronchi/abnormalities+Syndrome*. Many malformations are indexed under appropriate organ headings with the subheading 'abnormalities', for example, agenesis of the lung under *Lung/abnormalities* and polydactyly under *Fingers/abnormalities* or *Toes/abnormalities*, as appropriate. It is possible, however, to retrieve these concepts cleanly by the use of a combination of textwords and medical subject headings. For example, agenesis (textword) and *Lung/abnormalities*.

New syndromes showing combinations of abnormalities are indexed under appropriate combinations of medical subject headings for the major features of the syndrome discussed in the article, together with either the heading

Syndrome (if mentioned as such) or *Abnormalities*, *multiple* as appropriate.

The hierarchical arrangement of medical subject headings into 'trees' enables one to search for whole categories of headings so that, for example, a combination of any congenital heart defect with any sex chromosome abnormality is easily done using the 'explode' facility. It is thus possible to search for any degree of 'loose' or 'tight' combinations as appropriate to the circumstances and to modify the search formulation in the light of the number of citations found in the course of searching at any time. Aspects such as methods of diagnosis, differential diagnosis, and forms of treatment are also indexed and can be retrieved if required.

MEDLINE is widely available in Britain from a number of hosts including BLAISE-LINK through university and hospital libraries. Those without direct access to an online terminal may wish to make use of the BLAISE-LINK Search Service at this address. I will be happy to supply further details on request.

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Membranous glomerulonephritis in Hong Kong

Sir,

Recently Wiggelinkhuizen *et al*¹ and Hus *et al*² reported the high incidence of membranous glomerulonephritis in children with nephrotic syndrome and its strong association with hepatitis B surface antigenaemia in South Africa and Taiwan respectively. Chan and Tsao in 1966 reported a similar high prevalence of membranous glomerulonephritis in Hong Kong children with nephrotic syndrome or persistent proteinuria, but the hepatitis B surface antigen status was not assessed.³ We would like to report our recent experience in Hong Kong.

From January 1976 to June 1982, 43 Chinese children were admitted to this hospital with a diagnosis of idiopathic nephrotic syndrome. Patients with one or more of the following criteria underwent renal biopsy: steroid non-responsiveness; aged below 1 or over 8 years; presence of gross haematuria or hypertension; persistent azotaemia; frequent relapses; or persistent hypocomplementaemia. Thirty one of 43 patients were biopsied. Analysis of results showed that five had membranous glomerulonephritis, 16 minimal change nephropathy, five mesangial proliferative

glomerulonephritis, three focal segmental glomerulosclerosis, one diffuse proliferative glomerulonephritis, and one membranoproliferative glomerulonephritis. All of the five patients with membranous glomerulonephritis were hepatitis B surface antigen positive and all were boys aged 5 to 9 years (mean 7.8). None responded to steroids but their natural history has been one of slow recovery. Three patients remitted spontaneously after an interval of one to three years, while the remaining two had persistent, mild, asymptomatic proteinuria. Renal function did not show any deterioration over a follow up period of one to five years in all patients.

Our prevalence rate of 12% for membranous glomerulonephritis in children with nephrotic syndrome is quite high compared with that found by the International Study of Kidney Disease in Children in developed countries,⁵ but is comparable with areas where the incidence of hepatitis B surface antigen carrier status is high.^{1,2} Hepatitis B is endemic in Hong Kong and the prevalence of surface antigen positivity is 6.7% in the first decade of life.⁴ The association between childhood membranous glomerulonephritis and hepatitis B infection is very strong and all our patients with this were hepatitis B surface antigen positive. The mode of hepatitis B infection in these children is unknown. Vertical transmission is presumed to be the main infective mode responsible for childhood membranous glomerulonephritis in Japan,⁶ while horizontal transmission is thought to be more important in Taiwan.² None of our patients had a previous history of hepatitis and the interval between the time of infection and the onset of symptoms of membranous glomerulonephritis cannot be determined. Interpretation of the results of hepatitis B marker screening of the family members at the time of, or after the diagnosis would be difficult. A long term, longitudinal follow up study of infected subjects is required to elucidate this. We are presently undertaking such a study to look for the causal and time relation between hepatitis B infection and the development of membranous glomerulonephritis in children.

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Electrically heated gloves in children with Raynaud's phenomenon

Sir,

Raynaud's phenomenon may occur in up to 10% of the general population¹ but it is very rare in childhood. Many treatments have been tried with little long term benefit, including a wide range of drugs,² cervical sympathectomy,³ plasmapheresis,⁴ and behavioural therapy.⁵ More recently the use of electrically heated gloves was described in adult patients.⁶ We report the successful use of these gloves in two children (Table).

The acrylic gloves have an interknitted electrical heating element on the inner surface. Outwardly they look like ordinary knitted gloves and may be washed. They are heated from a battery pack worn on a waist belt and

Table Details of patients fitted with heated gloves

Case no	Sex	Age (yrs)	Diagnosis	Duration of Raynaud's phenomenon before glove trial	Ordinary lined gloves	Electrically heated gloves
1	F	9	Primary Raynaud's phenomenon	1 yr	Ineffective	Effective
2	M	13	Raynaud's phenomenon in association with scleroderma	4 yrs	Ineffective	Effective

Figure Electrically heated gloves.