Correspondence

Outcome for congenital hypothyroidism

Sir,

The study by Hulse¹ on children with congenital hypothyroidism provides useful retrospective data and prompts us to compare his findings with our own study in the northern region.² In a subgroup of 43 children we found a similar intelligence quotient (IQ) distribution (mean (SD) Weschler intelligence scales for children—revised (WISC-R) 82.4 (17.7)) and an association between IQ and social class. There was a trend to delayed diagnosis, however, in the lower social classes and lower IQ scores in those with severe bone age delay. The lower mean IQ scores in this and in Hulse's study compared with that of Macfaul³ could be the result of a difference in the social class distribution and in the degree of thyroid deficiency but it could also be due to the different tests used: WISC-R can give values about six points lower than those of the WISC test.⁴ We have also studied 43 adults with congenital hypothyroidism. Their IQ score was mean (SD) 92.2 (15.1) (Weschler adult intelligence scales test), but we found an IQ gain of mean 10.6 (5.4) in 16 of these adults who had been tested 10 years apart. This confirms that the IQ score of some patients may continue to increase with age even allowing for IQ test differences.

Coordination problems identified by using standardised motor assessment were common both in adults and children. We used the Bruinink's-Oseretsky test battery² in the children and we recommend this test for prospective studies of children diagnosed by screening.

Hulse¹ showed inappropriate treatment in some patients. In our study, 50% of the children were on doses of thyroxine higher and 20% on doses lower than recommended. Interestingly, although many had abnormal serum thyroxine and thyroid stimulating hormone values, few had any symptoms, presumably as a result of the protective effects of reverse triiodothyronine and triiodothyronine.⁵ Some of those with high serum thyroxine values, however, had bone ages advanced by two years or more. This emphasises the need to observe treatment recommendations in patients diagnosed early in order to avoid complications such as craniostenosis, and to ensure optimal subsequent clinical progress.

References

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Clinical significance of gastro-oesophageal reflux

Sir,

In his annotation on gastro-oesophageal reflux¹ Professor Carré states that radiologic studies are the most important and reliable means of distinguishing physiologic from pathologic reflux. In support of this statement he cites a 35 year experience together with his own publications. What he omitted to mention was that during this time the children studied were nursed upright. We now know that the prone position is the treatment of choice and furthermore the 'propped up' position may even be harmful.²⁻⁴ Because posture is the mainstay of antireflux treatment, his conclusion can only be regarded as suspect. I submit that the only way to distinguish physiologic from pathologic reflux is by careful clinical observation.

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Professor Carré comments:

The one comment in Dr Blumenthal's letter with which I can wholeheartedly agree is his reference to the importance of careful clinical assessment when evaluating the importance of gastro-oesophageal reflux and its treatment. He will, therefore, be pleased to know that my emphasis on the importance of a radiologically defined coexistent partial thoracic stomach (hiatal hernia) as a determinant of pathological reflux has been derived from long term detailed personal clinical observation of both treated and untreated infants with gastro-oesophageal reflux. In support of his contention that nursing infants with reflux in a sitting position may in fact be harmful Dr Blumenthal quotes the pH monitoring studies of Orenstein *et al.*³ He omits to mention that the validity of these particular studies has been questioned⁵ and makes no reference to the fact that conflicting results have been reported by other workers using a similar method of investigation.⁶ The value or otherwise of any treatment must ultimately be measured not by pH monitoring or other investigatory techniques but by careful clinical evaluation. Such studies have shown conclusively that the sitting position is