naissance. Séminaire de Néphrologie Pédiatrie Hôpital Necker/ Enfants Malades, Paris 26-27 March 1984.

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Mr Thomas comments:

Drs Roodhooft and Van Acker advocate a routine cystourethrogram for any neonate whose prenatal ultrasound scan has been equivocal—even though the initial postnatal scan shows an apparently normal urinary tract. This approach would certainly pick up the occasional child with unsuspected vesicoureteric reflux—but at the price of subjecting a large number of normal neonates to an unnecessary and invasive investigation. Until data becomes available to indicate the incidence of reflux in babies with ultrasonically normal upper tracts, I will continue to investigate only those with a degree of dilatation on the initial scan (or on a follow up scan at 1 or 3 months of age).

Much depends on the initial postnatal scan. In the case cited by Drs Roodhooft and Van Acker, it is perhaps surprising that the degree of dilatation associated with grade IV reflux was not detectable on the first scan when it had been visualised prenatally and later at 3 weeks of age. If the initial scan is, for any reason, technically unsatisfactory, it would certainly be prudent to repeat the scan at 1 month rather than the 3 months suggested in the annotation.

Clonidine and insulin tests for growth hormone deficiency

Sir,

The oral clonidine test has been recommended in the investigation of suspected growth hormone deficiency.^{1 2} While recognised that it may cause hypotension and drowsiness,³ it is thought to be preferable to the insulin tolerance test which is 'acknowledged to be unpleasant for the patient and potentially dangerous'.¹

We have, therefore, recently been using clonidine but have been concerned that the hypotension has sometimes been symptomatic. We should like to report the case of one child in which this was severe.

This girl was a growth retarded first twin who failed to match the growth progress of the second twin. While certain dysmorphic features were apparent we wished to

exclude remedial causes of growth failure including growth hormone deficiency. Two hours after an oral dose of clonidine (0.15 mg/m²) her blood pressure dropped from 115/70 to 85/40 (electronic doppler measurement using Dynamap, Critikon Ltd with appropriate cuff size), her pulse rising from 115 to 180/minute. She became pale and unresponsive with peripheral hypoperfusion, requiring resuscitation with intravenous plasma. Within half an hour she was well. The investigation showed her growth hormone response to be normal.

While recognising that this case is somewhat unusual, we do feel that it serves as a reminder that, like the insulin tolerance test, the clonidine test should not be undertaken lightly, requiring close patient monitoring and the immediate availability of resuscitative facilities.

References

- 1 Milner RDG, Burns EC. Investigation of suspected growth hormone deficiency. *Arch Dis Child* 1982;**57**:944-7.
- 2 Fraser NC, Seth J, Brown NS. Clonidine is a better test for growth hormone deficiency than insulin hypoglycaemia. *Arch Dis Child* 1983;**58**:355-8.
- 3 Gil-Ad I, Topper E, Loran Z. Oral clonidine as a growth hormone stimulation test. *Lancet* 1979;**ii**:278-80.

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Pallid syncope

Sir,

Like a malingering teenager, a toddler may overbreathe, hold his breath, and faint. What happens next depends on his position. If he falls flat he usually recovers quickly; if his mother picks him up and holds him upright in her lap or over her shoulder, unconsciousness and bradycardia are prolonged, and he may jerk like the unfortunate patient who faints while in the dentist's chair. The appearance is similar to that of the child whose vagus over responds to a stubbed toe. As Dr Bower¹ emphasises, the history is important; and advice to hold or leave the child horizontal may sometimes be more appropriate than atropine.

Reference

- 1 Bower BD. Pallid syncope (reflex anoxic seizure). *Arch Dis Child* 1984;**59**:1118-9.

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