LETTERS TO THE EDITOR

Clinical and laboratory findings in referrals for mitochondrial DNA analysis

EDITOR,—Like Lamont and colleagues,¹ we have found that mtDNA mutations are uncommon, even among children seen at a neurogenetic referral centre. Only three of 135 children in North Trent who we investigated for suspected mitochondrial disorder between 1995 and 1998 had a positive finding (NARP T8993G, MELAS, and mtDNA depletion).

However, it is likely that mtDNA studies alone will fail to diagnose many patients with mitochondrial disease. Additional investigative approaches including respiratory chain enzyme measurement can make a useful contribution to the identification of affected individuals.²⁻³ In our patients, two of the three with mtDNA abnormality and a further 15 without had reduced activity of one or more complexes. Maternal inheritance was more often associated with mtDNA abnormality (2 of 3 patients) than without (1 of 15). A lack of detected mtDNA abnormality was more frequently associated with parental consanguinity (5 of 15). Very young infants presenting with acute or subacute encephalopathy, who followed a severe course and died young, only occurred in the mtDNA negative group, particularly those with consanguinity. Epileptic seizures also only occurred in the group with biochemical abnormalities alone (6 of 15). Otherwise there was no difference in clinical features, either on presentation or follow up.

We accept that the interpretation of reduced respiratory chain enzyme activity is difficult and a modest reduction in activity without other supporting evidence cannot be considered diagnostic. The positive predictive value of individual results will be modified by related information and hence the likelihood of the disease in a given patient. The results from 15 of our patients without mtDNA abnormality but with evidence of reduced respiratory chain enzyme activity and clinical features consistent with those described in mitochondrial disease suggests the need for an approach to investigation that includes respiratory chain enzyme measurement. Assessing the significance of any abnormal results may prove a more difficult problem!

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Pertussis is increasing in unimmunised infants: is a change of policy needed?

EDITOR,—Our experience of pertussis infection in unimmunised infants is similar to that of Ranganathan *et al.*¹ Awareness of the illness has fallen and it may go undetected or unreported, even in the event of death.² The presenting features are atypical and may include apnoea or seizures.

We have managed nine cases of severe infantile pertussis recently, all but one presenting in the past two years. The patients presented between 2 and 6 weeks of age with a history of poor feeding and cough, bronchiolitis being the provisional diagnosis. Five were ventilated for recurrent apnoea, two for seizures, and two for respiratory failure. Six of them died. Ventilation was difficult as thick secretions produced areas of collapse, consolidation, and hyperinflation. Complications included pneumothorax, hypotension, pulmonary hypertension, seizures, and coinfection. One survivor required prolonged extracorporeal membranous oxygenation and high frequency ventilation in addition to 700 hours of conventional ventilation. In three cases the deterioration to death was rapid, with diagnosis being made postmortem.

We agree that the organism continues to circulate, often silently, among family members.³ In six of our cases the mother was symptomatic and thought to be the source of infection. Immunisation produces temporary immunity making adults susceptible to infection. We were unable to confirm immunisation in all of the mothers. There is now a cohort of adults whose parents declined vaccination during the 1970s who are susceptible to primary infection and of reproductive age. This fatal resurgence in infantile pertussis should lead to a debate on reviewing the accelerated immunisation schedule.⁴ If the safety of the newer acellular vaccines are accepted, then their use in later childhood or adolescence may be necessary to halt this trend. In the short term a new generation of general practitioners and paediatricians need to be aware of these aspects of pertussis and have a higher index of suspicion, only then will the prevention of secondary transmission be possible, particularly in the presence of a new baby.

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How to manage warts

EDITOR,—We wish to enlarge on the association between anogenital warts (AGW) and child sexual abuse, which Verbov alluded to in his paper on the management of warts.¹ The population prevalence of AGW is not known, and in adults the warts are transmitted predominately through sexual intercourse after an incubation period of several months.²

How often child sexual abuse is found in children with AGW depends on how thoroughly they and their families are investigated,^{2,3} and figures quoted range from 31-63%. In a Leeds study of child sexual abuse the prevalence of AGW was 1.5% and the prevalence of sexually transmitted disease (STD) was 2.7%.⁴ A similar UK study found no AGW but a prevalence of STD of 3.7%.⁵

Current literature suggests that:

- AGW in adults are predominately sexually transmitted, the incubation period is several months
- the virus (human papillomavirus) may be transmitted in utero or during birth and may not be manifest until the child is 2 years old (but all children who have warts require investigation for other STD and the possibility of child sexual abuse).^{2,6}

Suggested investigations and management include:

- a paediatric assessment
- behavioural indicators
- tests for other STD in the child and carers
- typing of warts is expensive and may be misleading as non-genital wart types may be sexually transmitted—for example, digital and genital wart types transmitted in utero
- a social worker with or without police investigation
- follow up appointments for adolescents are recommended, joint clinics with genitourinary physicians are ideal⁵
- follow up of prepubescent children is more difficult and currently we refer back to the general practitioner for assessment, possibly at the first family planning clinic
- locally, treatment of AGW is surgical.

Early recognition of AGW as a marker for child sexual abuse may allow early cessation of the abuse, giving the child an improved chance of developing into a mature adult with the ability to form lasting relationships.

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- 1 Verbov J. How to manage warts. *Arch Dis Child* 1999;80:97-9.
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BOOK REVIEWS

Paediatrics and Child Health. Edited by Levene M. (Pp 416; paperback; £24.95.) Oxford: Blackwell Science Ltd, 1999. ISBN 0 865 42957 X.

The "unique selling points" of this book are its problem orientated approach, boxed summaries of important topics, and integrated cover of community child health in addition to hospital paediatrics. As with all modern textbooks for the medical student this has plenty of

colour and many illustrations, with enough lists to learn to make revision feel meaningful.

Does it succeed as a new breed of textbook? Problem orientated approaches are certainly fashionable, and reading this feels more realistic than the older approaches of system based disorder. This also makes the book a bit difficult to use as a reference text. The "at a glance" summary boxes are packed full of information and usually helpful.

I found the main strength of this book in the sensible, informative approach to child health issues. The developmental theme is woven into the book, not just in the community chapters. Acute paediatrics is covered in sensible detail, addressing common problems in much greater depth than competing books but sacrificing the snippets of rarities examiners may consider essential. There is too little information to make this a useful book for MRCPCH (member of the Royal College of Paediatrics and Child Health examinations) and there are very few references or suggestions for further reading.

Another colourful textbook of paediatrics might be the dulllest book buy of the year; however, if I was to re-run my (not too distant) days as a medical student, I may have been tempted by this book.

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WESTMINSTER BRIEFING

The following items are from *Children & Parliament*, spring/summer 1999. *Children & Parliament* is an abstracting service based on *Hansard* and produced by the National Children's Bureau. It covers all parliamentary business affecting children and is available on subscription via the internet (<http://candp.ncb.org.uk>). The *Children & Parliament* web site provides direct links to full text *Hansard*, government department sites, the sites of the Office for National Statistics, Ofsted, and other relevant organisations. For further details contact Lisa Payne, Editor, *Children & Parliament*, National Children's Bureau, 8 Wakley Street, London EC1V 7QE, UK (tel: +44 (0) 171 843 6000; fax: +44 (0) 278 9512). (The *Hansard* reference is given in parentheses.)

- Thirty-six MPs had signed a motion calling on the government to promote more public education on the dangers to children of parental smoking and to support general practitioners in their attempts to reduce smoking by parents.
(23 Mar 1999, Col 182–183, 198)

- New nutritional standards for school meals should be published in the autumn of 1999. A joint Department of Health/Department for Education and Employment National Diet and Nutritional Survey of 4–18 year olds has been performed and the results should be reported towards the end of 1999.
(31 Mar 1999, Col 737–738, 828)

- The Home Office and the Department for International Development are working with countries in Asia, particularly Nepal and Thailand, to develop measures to protect children from exploitation and "sex tourism".
(13 Apr 1999, Col 618–620)

- During a 3 year Quality Protects programme a team of Regional Development Workers will join with the Social Services Inspectorate to help local authorities to deliver children's social services of high quality.
(13 Apr 1999, Col 113–114, 111)

- An existing European guideline states that medicines likely to be used for children should be supported by clinical trials in the appropriate age group. It is aimed to have a single guideline adopted by Europe, the USA, and Japan.
(19 Apr 1999, Col 669–678)

- Tattooing may not be done on people under the age of 18. Four MPs had signed a motion calling for a similar ban on body piercing other than for the wearing of ear rings.
(21 Apr 1999, Early Day Motion no 569)

- The Adoption (Intercountry Aspects) Bill, given an unopposed second reading in April, will regulate adoption between countries. Local authority adoption services will need to take on board intercountry adoptions. The Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption will be ratified, child trafficking will be prevented, and children adopted from abroad will have the same legal status as children adopted within the UK. The adoption process will be speeded up and will be more child focused.
(23 Apr 1999, Col 1140–1202)

- The 26 health action zones will receive £10 million this year to help people in deprived areas to stop smoking. Smokers receiving benefit, including lone parents on income support, will get one week's free nicotine replacement therapy.
(23 Apr 1999, Col 1212–1216)

- The use of children as soldiers is a war crime in the statute of the International Criminal Court. UK government assistance to Sierra Leone amounting to £10 million was given on the condition that Sierra Leone would not enlist children under 16 in the armed forces.
(28 Apr 1999, Col 179)

- The Control of Fireworks Bill, which had its first reading in May, seeks to ban the sale of fireworks to the public.
(11 May 1999, Col 116–118)

- For the next 3 years the government will provide £7.5 million each year through the Standards Fund programme to support school education about drugs.
(19 May 1999, Col 388–389)

- The main targets of the antidrugs coordinator's strategy include reducing access of young people to heroin or cocaine by 25% by the year 2005 and by 50% by 2008, reducing the number of 11–16 year olds using class A drugs by 20% by 2002, and increasing participation of drug misusers in treatment programmes.
(25 May 1999, Col 161–173)

- It is estimated that some 6000 people in the UK have sickle cell disease. The Department of Health has provided funding to organisations and is considering the need for a national health promotion programme for the haemoglobinopathies.
(7 Jun 1999, Col 121–122)

- In answer to a question about school medical services the Under Secretary of State for Health replied that they will have a major role in meeting children's mental, physical, and emotional health care needs and many of the government's policy initiatives are dependent on an effective school health service.
(8 Jun 1999, Col 271)

- Under the School Access Initiative the government has allocated £25 million since 1996 and will allocate another £100 million over the next 3 years to make mainstream schools accessible to disabled pupils.
(10 Jun 1999, Col 391)

- Masterclasses for gifted and talented children are being piloted in 10 schools and there are to be 40 summer school pilot projects. Schools in the 25 education action zone pilot areas will have to designate one member of staff to monitor gifted children.
(10 Jun 1999, Col 766–768)

- The government believes that some local authorities could and should do more to facilitate adoption. Adoption should be reinstated as an option for the placement of some children in care, objectives being to maximise the use of adoption, reduce delays, and reduce the number of changes of main carer.
(16 Jun 1999, Col 349–355)

- A national monitoring scheme for court cases involving child witnesses has been in operation since April 1999. The purpose is to make sure that such cases are dealt with as quickly as possible and to identify ways in which improvements can be made.
(29 Jun 1999, Col 136)

- From October 1999 an amendment to the Consumer Protection Act 1987 will make it an offence to sell gas cigarette lighter refills to people under the age of 18.
(28 Jun 1999, Col 86 [Press Notice 189/99])

- A review by the Prison Service of the care of mothers and their babies or children in prison was published on 6 July and contains 62 recommendations. An action plan is to follow in the autumn.
(6 Jul 1999, Col 484, 81)

- The government is to provide £90 million over the next 3 years to improve the provision of child and adolescent mental health services.
(6 Jul 1999, Col 804)

- In the House of Lords a questioner asking about the possible contribution of water fluoridation to the high perinatal mortality in an English city was informed that research was being focused on known risk factors applicable to that city rather than on speculative investigation.
(9 Jul 1999, Col 130)

- In 1991 about a quarter of people in prison in Britain had been taken into care as children.
(15 Jul 1999, Col 319–320)

- The Children's Rights Commissioner Bill will establish a children's rights commissioner in England.
(14 Jul 1999, Col 417–418)

- The Protection of Children Act 1999 received royal assent on 15 July.
(15 Jul 1999, Col 648, 601)