Correspondence

Archives of Disease in Childhood, 1975, **50**, 668.

Association of diabetes and coeliac disease

Sir,

I read with interest the report of Dr. Chambers (1975) in the *Archives*, describing yet another child with coexistent coeliac disease and diabetes mellitus and also for the first time coexistent hyperthyroidism. The association between diabetes mellitus and coeliac disease is now well documented (Walker Smith, Vines, and Grigor, 1969; Visakorpi, 1969; Thain, Hamilton, and Ehrlich, 1974). One partial explanation for this association may be a common genetic predisposition. Approximately 80% of children with coeliac disease have the histocompatibility antigen HL-A 8 (McNeish, Nelson, and MacKintosh, 1973). Cudworth and Woodrow (1974) have also found that 54% of patients with juvenile onset diabetes have the HL-A 8 antigen. It has been suggested that one or more immune response genes predisposing to coeliac disease are in linkage disequilibrium with HL-A 8 (Strober, 1974). This may be the basis for predisposition to both coeliac disease and diabetes mellitus that possession of these HL-A 8 antigens appears to endow.

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Fatal pneumococcal septicaemia in an 8-year-old child after splenectomy for trauma

Sir,

It is usual to defer elective splenectomy in young children until after the age of 4 on the grounds that their defences against infection may as a result be impaired up to school age. Even after this age some physicians prescribe long-term antibiotic prophylaxis because of the risk of infection, particularly pneumococcal, to which they are markedly susceptible. Eraklis *et al.* (1967) reviewed 467 splenectomized children mostly above this age and found no mortality from overwhelming infection among those children whose spleens had been removed after accidental injury. It may be thought from this experience that when the indication for splenectomy was trauma, antibiotic prophylaxis was not necessary. A recent case in our care suggests differently.

An 8-year-old boy who 10 months previously had splenectomy after an accident was admitted with a 4-hour history of pyrexia but otherwise was not manifestly ill. He was put on antibiotic pending results of blood culture. During the next few hours his condition deteriorated dramatically and he died 6 hours after admission. All 3 blood culture bottles yielded a growth of pneumococci. The post-mortem findings were essentially negative. No splenic tissue was found.

Having had this experience we have advised our surgical colleagues to keep such children on antibiotic prophylaxis. We do not know when this should be discontinued but arbitrarily suggest age 10 years.

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Monoparesis following CPAP

Sir,

May we report another example of monoparesis as a complication of CPAP with a head box. A male infant, birthweight 2190 g at 35 weeks' gestation, developed respiratory distress syndrome soon after birth. At age 34 hours he was placed in a Vickers head box with a maintained pressure of 10 cm. He remained in the box, gradually improving, until the 6th day. After his transfer to an incubator he became pyrexial within 24 hours and then gravely ill with staphylococcal septicaemia, including localized collections of pus in the skin over the skull, sternum, and sacrum. With antibiotics he slowly improved and as he was becoming more vigorous on the 12th day, abnormality of the left arm was noticed. There was complete paralysis of deltoid, a flicker of movement in biceps, and grasp reflex was normal. Before discharge on the 36th day some shoulder movement was noticed, and at follow-up the left arm was considered normal by 3 months of age.