Correspondence

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Sterilization of children under 16 years of age

Sir,

The Department of Health and Social Security has recently prepared a discussion paper on 'Sterilization of Children under 16 Years of Age'. The document has had wide distribution and views have been sought from a large number of organizations, particularly the professions likely to be involved, together with a range of organizations concerned with the welfare of children. Because this is a subject of especial concern to paediatricians, the British Paediatric Association would like to make its comments more widely known.

There are two distinct groups to be considered: the first in which sterilization proves unavoidable in the course of treatment of a serious medical condition (therapeutic sterilization), and the second in which sterilization of children with severe mental handicap is undertaken in order to prevent the possibility of pregnancy (nontherapeutic sterilization). In some of the latter cases the fetus may also be at considerable risk (e.g. maternal phenylketonuria).

In the case of therapeutic sterilization the decision must be made by the doctor in charge of the case. In an important issue of this kind it would be advisable to follow the normal practice of obtaining a second opinion, but this may not always be possible—for instance when during the course of an operation for cancer involving the pelvic organs the surgeon finds that removal of the uterus and/or ovaries is necessary.

It was suggested in the Department's discussion paper that there may be certain genetic indications. After taking expert advice we are clear that the presence of a genetic condition alone cannot justify sterilization under the age of 16 years.

A decision regarding nontherapeutic sterilization should not be made by a single doctor; there are too many issues concerning the accuracy of diagnosis, prognosis, and genetic implications, etc. Professional consultation should include further medical opinion, and for particular children the opinion of medical social workers, psychologists, and other health workers should be sought. It is understood that confidentiality will be observed by all involved in these consultations. Full discussion with the parents (and where possible explanation to the child) should, of course, precede the final decision.

Although it will be necessary in all cases to consider the problem against the background of the family including the risks to the baby who might be conceived, the interests and well being of the child concerned (i.e. the girl for whom sterilization is being considered) should be paramount. No parent should be able to secure a daughter's sterilization because it is feared that the child may become promiscuous. Wherever possible decisions on sterilization should be postponed until the age of consent. We realize, however, that in cases of severe mental handicap the individual may never be able to give informed 'consent', and we would wish to see a procedure which safeguards the interests of all such persons irrespective of age.

We are not in favour of a central registry or any form of notification.

Decisions should not be delegated to ethical committees. If after consultation consensus cannot be reached then a Ward of Court Procedure should be followed.

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Poststreptococcal nephritis—still not a rare disease in Thailand

Sir,

Dr. Meadow (1975) reported in the *Archives* that poststreptococcal nephritis is no longer the main cause of childhood acute nephritis in the Leeds area. This may also be true for other areas of Britain, as he suggested. May we report the high incidence of poststreptoccocal nephritis from January 1972 to December 1975 as seen at Ramathibodi Hospital, one of the 4 university hospitals in Bangkok, a city of 4 millions population.

Seventy children, 2–15 years old, with hypertension, and with preceding sore throat or pyoderma met the criteria as previously described (Meadow, 1975). ASO titre above 1: 340, or more than twofold increase upon subsequent determination was considered significant (Petchclai *et al.*, 1973a). Complement levels either determined as C3 complement by a radial diffusion method (Mancini, Carbonara, and Heremans, 1965) or as total haemolytic complement by the method previously described (Petchclai, *et al.*, 1973b) were considered significantly depressed at <80 mg/100 ml or 50%, respectively. 25 of the patients had increased ASO titre, and all had depressed complement levels.

Another 55 children who were not hypertensive but had microscopical haematuria and history of facial oedema of more than a week before referral to the renal clinic, also had depressed complement levels. 10 of them had increased ASO titre. We have not routinely performed throat swab culture since antibiotics are available to the population without prescription. In conclusion, we have seen 125 children with poststreptococcal nephritis in the past 4 years.