control series among girls is significant at the \( P < 0.005 \) level, whereas a difference of 6.6 cm between the corresponding groups of boys was not significantly different. The same type of argument can be applied to the weight data, and one is left with the feeling that this might not be a real difference between boys and girls as claimed by the authors in their discussion, but rather simply a consequence of the small sample size making what would otherwise be substantial differences in fact not statistically significant. Alternatively, there may be so much variation between individuals in the index and control groups that this amount of difference is indeed not significant. I think it would strengthen the case being made by the authors with regard to the long-term effects of infantile malnutrition if this additional information could be made available to the reader.

J. A. BIRKBECK

Nutrition Department,

University of Otago,

Box 56, Dunedin, New Zealand.

Dr. M. B. Stoch and Prof. P. M. Smythe comment:

With apologies, there is an error in our statistics. The group results were computerized but the subgroups were not, which on rechecking by computer showed two errors. The significance of the difference between the index and control girls in regard to height should be \( P < 0.05 \) and not \( < 0.005 \). The nonsignificance between index and control boys in regard to height is correct, so the validity of our conclusions is not altered. A similar error was found in the difference between index and control girls in the Bender Visual-Motor Gestalt; the \( P \) value for this should also be \( < 0.05 \) and not \( < 0.005 \).

In reply to Prof. Birkbeck's request for information about the range, the figures are given in the Table, together with the figures for weight.

M. B. STOCH and P. M. SMYTHE

University of Natal, Faculty of Medicine,

Department of Paediatrics and Child Health,

P.O. Box 17039, Congella 4013, Durban,

South Africa.

Table Heights and weights (boys, \( n=18 \); girls, \( n=22 \))

<table>
<thead>
<tr>
<th></th>
<th>Mean (cm)</th>
<th>SD</th>
<th></th>
<th>Mean (cm)</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Height</strong></td>
<td><strong>Index</strong></td>
<td><strong>Control</strong></td>
<td><strong>Index</strong></td>
<td><strong>Control</strong></td>
<td><strong>t</strong></td>
</tr>
<tr>
<td><strong>Boys</strong></td>
<td>157.89</td>
<td>164.54</td>
<td>7.526</td>
<td>10.333</td>
<td>1.564</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>148.92-</td>
<td>142.24-</td>
<td>174.32</td>
<td>175.89</td>
<td></td>
</tr>
<tr>
<td><strong>Girls</strong></td>
<td>149.20</td>
<td>154.81</td>
<td>6.132</td>
<td>5.956</td>
<td>2.238</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>140.66-</td>
<td>146.68-</td>
<td>160.02</td>
<td>166.70</td>
<td></td>
</tr>
<tr>
<td><strong>Weight (kg)</strong></td>
<td><strong>Boys</strong></td>
<td><strong>Girls</strong></td>
<td><strong>Boys</strong></td>
<td><strong>Girls</strong></td>
<td><strong>t</strong></td>
</tr>
<tr>
<td><strong>Boys</strong></td>
<td>44.57</td>
<td>49.42</td>
<td>6.855</td>
<td>11.439</td>
<td>1.091</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>35.00-</td>
<td>35.00-</td>
<td>55.68</td>
<td>72.73</td>
<td></td>
</tr>
<tr>
<td><strong>Girls</strong></td>
<td>41.03</td>
<td>47.38</td>
<td>7.975</td>
<td>5.022</td>
<td>2.021</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>29.09-</td>
<td>39.77-</td>
<td>56.14</td>
<td>55.90</td>
<td></td>
</tr>
</tbody>
</table>

Prophylactic isoniazid dosage in newborn infants

Sir,

Dr. McKenzie and her collaborators (1976) reported in the Archives a case of neonatal pyridoxine-responsive convulsions due to prophylactic anti-TB therapy with isoniazid, in a dose of 13.8 mg/kg daily. The authors conclude that doses of isoniazid to newborn infants should not be greater than 10 mg/kg per day. As experience with prophylactic isoniazid administration to newborns is limited, I quote here Sifontes (1970), from Puerto Rico, who thinks that a daily dose of 10 mg/kg to newborns is not safe, as "some of these infants become irritable and show signs of central nervous system stimulation which disappear when the dose is lowered".

He suggests a daily dose of 3-5 mg/kg for the first 2 months of life, which then is increased to 5-10 mg for at least one year.

ALEX. PEONIDES

Children's Asylum Maternity Hospital,

Thessaloniki, Greece.

References


Dr. G. Katz comments:

We did not wish to give the impression that 10 mg/kg per day was the appropriate dose for the neonate, but tried to stress the point that doses in excess of this are dangerous. We are in fact in full agreement with the recommendations of Sifontes.

G. KATZ

Edgware General Hospital,

Edgware, Middlesex HA8 0AD.