Correspondence

Arthritis after measles

Sir,
A very unusual complication of measles was seen in two children recently. A 2-year-old healthy boy showed a typical measles infection. Two weeks after the onset, he suddenly complained of severe pain in the elbows, wrists, and knees, with swelling of these joints; he had several erythematous indurations on his arms and back, particularly on the left side. Maximum temperature was 38.5°C. All symptoms disappeared in 2 days. Measles antibody titre 6 weeks after the onset was 1/8, 9 months later 1/32.

A 4-year-old boy developed painfully swollen knees and ankles, and a generalised indurated erythematous eruption 10 days after typical measles. There was slight fever (38.2°C). The symptoms disappeared after about 12 hours. Measles antibody titre 2 weeks after the onset was 1/8, and after 9 months 1/16. The corresponding rubella antibody titres were 1/8 and 1/64.

The boys had had no contact with each other.

About one year later, symptoms had not reappeared in either boy. Although articular complications are well known after some viral infections, I am not aware of such an association with measles.

ROBERT F M F VAN HOREBEEK
J de Troozlaan 10,
B-8370 Blankenberge,
Belgium

Incidence of dental caries in coeliac children

Sir,
Because of our prolonged postal strike, we have only recently read the letter from Mr E D Fulstow (Archives, 1979, 54, 166). We have completed a survey of the incidence of decayed, missing, or filled teeth in 33 coeliac patients, 22 under and 11 over twelve years, attending primary schools in Co. Galway. When compared with the teeth of 68 siblings, there was no significant difference in the incidence of caries.

M J MCLoughlin and S Mcneill
Dental Department,
Western Health Board,
Galway, Eire

Acquired toxoplasmosis in children

Sir,
In their letter (Archives, 1978, 53, 829), Williams and Savage suggested that 'co-trimoxazole . . . should be the first choice of treatment in toxoplasmosis'. I believe their interpretation of their experience is premature and their conclusion wrong. Have we not yet learned from experience with other antimicrobial agents, most recently idoxuridine in the treatment of herpes simplex encephalitis, to recognise the necessity for appropriately performed studies before decisions are made on 'drug of choice'? Their patient, as well as many of those reported in their references, had the self-limiting, lymphadenopathic form of toxoplasmosis. The report by Norrby et al.3 is an example. Such cases provide no satisfactory information on the usefulness of co-trimoxazole in the treatment of patients with toxoplasmosis. It may be that this drug combination (co-trimoxazole) will prove efficacious, but before it is recommended as 'the drug of choice' for any form of toxoplasmosis (especially in life-threatening toxoplasmosis in immunocompromised patients and congenital toxoplasmosis), objective studies are needed both in the congenital infection in infants and in the acquired infection in adults.

Reference


JACK S REMINGTON
Department of Medicine,
Division of Infectious Diseases,
Stanford University School of Medicine,
Stanford, California 94305, USA

JOHN REMINGTON

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children, overt vitamin D deficiency rickets was diagnosed concomitantly with their coeliac disease. The ages at diagnosis of these three were 7, 10, and 11 months; their ages when first symptomatic were 4, 9, and 7 months. In the other six cases, where no overt rickets was recorded, the ages at diagnosis were 7, 18, 19, 21 months, 2 years 4 months, and 4 years 10 months, the ages when first symptomatic being 4, 16, 6, 8, 8, and 5 months. We are now analysing the time sequences of coeliac disease, rickets and, according to the teeth affected and the extent of hypoplasia, the possible concordance or discordance with the time of mineralisation of the affected areas in the diseased teeth. We feel that rickets, even when not clinically or biochemically evident, as is often the case in untreated coeliac disease, could be relevant to the development of enamel hypoplasia.

References

E Eggermont
Kinderkliniek,
Academisch Ziekenhuis Gasthuisberg,
3000 Leuven, Belgium

Diagnosis and management of folate deficiency in low birthweight infants

Sir,

I read with interest the paper by Strelling et al. (Archives, 1979, 54, 271). Although the erythrocyte folate levels suggested folate deficiency, the babies were too young to have megaloblastic anaemia. Herbert showed that serum folate level decreases early (about 7 weeks) and it takes nearly 19 weeks for the real megaloblast to appear in the bone marrow.

The mean reticulocyte count for the babies was 2.64% (range 0 to 6, Table 1) which would not be expected in real megaloblastic anaemias. The rise of Hb and haematocrit values (such as 0.3 and 1%) in 2 to 4 weeks’ treatment are well below a response to treatment.

Because of the feeding history (including iron supplement), the ages of the babies, and the slightly high reticulocyte count for age, I should like to see studies (such as hydrogen peroxide test and vitamin E levels) to exclude vitamin E deficiency. It is well known that megaloblastic changes of erythroid precursors occur in haemolytic anaemias regardless of the cause.

References

Sinaşı Ozsoyulu
Institute of Child Health,
Hacettepe University,
Ankara 11191,
Turkey

Drs Strelling and Goodall comment:

Professor Ozsoyulu expresses doubts on theoretical grounds that our patients could have had megaloblastic anaemia related to folate deficiency when aged only 5 to

Neonatal effects of maternal therapy with tricyclic antidepressant drugs

Sir,

We read with interest the letter by Ben Musa and Smith (Archives, 1979, 54, 405) on withdrawal symptoms, mainly instability of body temperature and jittersness, in a neonate affected by maternal clomipramine intake. In 1972 we reported on three term infants born of mothers who took imipramine during pregnancy. Transient, alternating episodes of hypokinesia and jerky movements were seen in all three. One baby convulsed on day 2. Transient tachypnoea and poor peripheral circulation were also common findings. In 1973 Webster described another baby with similar symptoms. On the other hand, Shearer et al. observed pronounced urinary retention in a neonate secondary to maternal ingestion of nortriptyline. Our third patient too, was irritable and showed ‘belly dance’ movements before voiding. Although hypothermia is only mentioned by Ben Musa and Smith, it is noteworthy that Wattiaux-De Coninck et al. could demonstrate the fixation of radioactive imipramine on mitochondria. The action of imipramine on oxidative phosphorylation, and hence on thermogenesis, could explain the occurrence of hypothermia in some of the affected neonates.

Present data suggest that tricyclic antidepressant drugs, given to the mother during pregnancy, may impair the adaptation of the neonate to extrauterine life.

References