Reference


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Dr Forrester comments:
I am pleased that my paper struck some chords as was shown by a recent letter in the *Archives* and by several letters sent to me, including one from a senior paediatrician in France who wrote 'Il n'y a pas un mot à changer pour décrire la situation que nous avons ici également—et nous avons ici aussi la même incompréhension des administrateurs d'hôpital...'.

It is only fair to add that in 20 years I had no problem with my own hospital administrators who seemed to understand, at local level, the logic of the empty bed. Officially there were no methods for recording the true state of affairs on my ward (see Dr Hardy's letter) and my figures were obtained from a meticulously kept ward admission book which I started in 1958 and which, to my knowledge, was still being kept in 1980 contrary to the prevailing custom in the hospital which 'abolished' such books years ago. I believe that my successors regarded it, as I did, as the main receptacle of truth.

In summary: empty paediatric beds can admit children—urgently; ward admission books are essential; anyone can keep an acute children's ward full, but it takes hard and thoughtful work by nursing staff and resident doctors to keep it half empty.

Symptomatic zinc deficiency in a breast-fed infant

Sir,

Like Ahmed and Blair we were treating an entirely breast-fed infant with symptomatic zinc deficiency at the time of publication of the paper by Aggett et al. We had hoped that our patient's symptoms were a transient manifestation of postnatal deficiency but at age 1 year she has now relapsed twice and must be considered as a case of acrodermatitis enteropathica.

Case report
A girl was born at 32 weeks' gestation weighing 1620 g. There were neonatal problems including a superficial pustular abdominal skin rash (*Staphylococcus aureus*) which desquamated after treatment. On the special care baby unit she was fed almost exclusively on breast milk and was discharged fully breast feeding 6 weeks after birth.

Two weeks later an eruption started on the neck and perianal regions. From these two sites the eruption spread by lateral extension to affect the face, particularly around the mouth, lower abdomen, gluteal cleft, and upper inner thighs. The toes were also affected. At its onset (and at times of relapse) the mother described the eruption graphically as looking like a burn and seeming sore; the skin became crinkled and then started to peel. On examination the eruption consisted of two large sheets affecting the above sites which were remarkably symmetrical. The edges were scaly and crusted while the skin of the central areas was returning to normal. The nails and hair seemed to be unaffected. Local treatment with a potent steroid-antibacterial-antifungal ointment was effective initially but when stopped the eruption recurred, she became intensely irritable, and stools were loose. At 15 weeks the infant's serum zinc was 5.8 μmol/l (normal 8.4–23.0), the mother's serum zinc was 11.4 μmol/l (normal) and her breast milk zinc was probably low at 5.2 μmol/l.1 2

The skin eruption and the baby's demeanour improved strikingly within 24 hours of starting zinc sulphate 50 mg three times a day. Treatment was stopped after 5 weeks when the serum zinc was normal but 8 weeks later she relapsed and the zinc level had fallen to 5.6 μmol/l.

Rapid clinical response occurred when zinc sulphate was reintroduced. A second relapse and response has occurred at age 12 months.

Unlike Aggett's case, our patient appears to be permanently zinc-dependent, but it is important again to stress that fully breast-fed (preterm) infants can show overt signs of zinc deficiency and that the skin eruption has a characteristic appearance.

References


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