Postmortem examination unexpectedly showed concurrent cytomegalovirus pneumonia. This is not uncommonly seen in immune suppressed patients. Cytomegalovirus was not grown from the maternal cervix, and although the possibility that the infection was acquired from one of several top up transfusions was considered, this could not be confirmed.

In any neonate with non-responsive neonatal pneumonia, congenital tuberculosis should be considered.

We thank Dr Maeve Keaney for constructive advice, the Department of Medical Illustration at Hope Hospital, and Jacqueline Buckley for secretarial help.

References

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Received 4 February 1986

Specific malabsorption of vitamin B₁₂ in Down’s syndrome

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SUMMARY A 3 year old girl with Down’s syndrome became lethargic and withdrawn, and investigations showed a specific malabsorption of vitamin B₁₂ without proteinuria.

Megaloblastic anaemia due to specific malabsorption of vitamin B₁₂ is usually associated with proteinuria. Urban et al reviewed the published reports in 1981 and found only six cases without proteinuria, and Conway et al reported a further case with neuropathy but without proteinuria. There is often delay in diagnosing a new problem in a child with Down’s syndrome, and we report this association to emphasise the need to take seriously the development of new symptoms, rather than attributing them to the syndrome.

Case report

A 3 years and 4 months old girl of unrelated parents who was under regular review because she had Down’s syndrome presented with new symptoms developing over one month. She suffered one episode of unproven haematuria followed by two weeks of watery diarrhoea. She then developed diurnal enuresis, cold cyanosed peripheries, lethargy, irritability, anorexia, and a scaly erythematous non-itching rash over an elbow and became withdrawn. She had lost 350 g in six months, her weight being 9650 g (2000 g below the third centile). Her height was just below the third centile with a normal height velocity. On examination she had typical features of Down’s syndrome and, in addition, was pale and miserable and had an area of discoid eczema over her left elbow.

The following investigations yielded normal results: plasma urea, creatinine, electrolytes, calcium, phosphate, albumin, glucose, bilirubin, and thyroidine concentrations, alkaline phosphatase, alanine transferase, and γ-glutamyltransferase activities, urine analysis and culture, throat and cough swabs, faecal microscopy and culture, and chest x ray films.

The peripheral blood film showed a pancytopaenia with macrocytic normochromic red cells (haemoglobin=5.9%, mean corpuscular volume 107±6 fl mean corpuscular haemoglobin 35.9 pg, white cell count 3.41×10⁹/l, neutrophils 0.550×10⁹/l, platelets 47±10⁹/l). Erythrocyte sedimentation rate was 9 mm in the first hour. The bone marrow was megaloblastic. Serum total cobalamin was 80 ng/l (normal range 300–1100 ng/l), red cell folate 240 mcg/l (normal range 130–600 mcg/l), and serum folate 15.4 mcg/l (normal range 2.6–14 mcg/l). Intrinsin factor antibody, parietal cell antibody, and
Specific malabsorption of vitamin B₁₂ in Down's syndrome

M DAVENPORT

Department of Paediatric Surgery, Leeds General Infirmary

SUMMARY A case is presented of transplacental malaria in an infant associated with persistent conjugated hyperbilirubinaemia and liver disease.

Malaria presenting in the neonatal period is a rare disease even in endemic areas.

Neonatal malaria and obstructive jaundice

M DAVENPORT

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Case report

A female term infant was born in Bradford, England, weighing 2800 g to Indian parents of a consanguinous marriage who had two other healthy children weighing 5600 g at term and 1700 g at 32 weeks. The mother had spent four months of the pregnancy in India, and two days after delivery a