

Dr Ounsted comments:

We entirely endorse the views of Dr Whitehead and his colleagues. Their head circumference findings are particularly important as they have shown elsewhere⁴ that from 4 months onwards the weights and skinfold thicknesses of babies born in the 1980s and fed in a manner more or less in line with 'Present day practice in infant feeding'⁵ were well below the median of the standards currently in use. Both studies draw attention to a positive secular trend in head growth in the last 30–40 years. Centile curves were created from our own data, and due to the relatively small numbers the 95% confidence limits were fairly large. Nevertheless, at no point from birth to 7 years did the 50th centile of the UK standard charts⁶ fall within the confidence limits of our mean values for either sex. The differences between the two sets of data were greater for boys than for girls and more pronounced at the upper than the lower end of the distribution from 3 years onwards. Up to date charts are urgently needed for the assessment of head circumference growth in the present generation.

References

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This correspondence is now closed—Ed.

Congenital hypothyroidism missed on screening

Sir,

The claim by Grant *et al* that three cases of congenital hypothyroidism were missed in the first five years of screening in Northern Ireland is a cause for concern.¹ Closer scrutiny of their data suggests, however, that all three cases should have been detected on the evidence available in the neonatal period. Thyroxine screening alone is generally recognised to be too insensitive. Nevertheless, whole blood thyroxine concentrations of 41, 38, and 53 nmol/l, respectively, are below the normal adult range, let alone the higher range documented for normal infants.² The fact that concomitant thyrotrophin concentrations were all <25 mU/l should not have deterred recall and further investigation even if congenital thyroxine binding globulin deficiency had explained the results. We would also question the wisdom of the whole blood thyrotrophin cut off value for recall. Our policy is to repeat

a blood spot thyrotrophin evaluation from the same card for values between 10–20 mU/l; if confirmed in this range, a further blood spot is collected for analysis. Any value >20 mU/l dictates recall for a venous blood sample.

In the first five years of screening for congenital hypothyroidism in Wales 161 239 infants have been tested and 29 hypothyroid infants identified. The lowest blood spot thyrotrophin concentration in the hypothyroid group was 55 mU/l. To our knowledge, no cases have been missed. We wish to reassure paediatricians that the present screening policy used in most centres in Europe is reliable but never infallible. Clinicians should not hesitate to institute a further check on thyroid function if symptoms and signs of hypothyroidism are suspected.

References

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Turner's syndrome

Sir,

In Dr Brook's interesting article on personal practice in Turner's syndrome he states that there is often 'misapprehension about intelligence' in these patients and 'that an academic career is not precluded'.¹ He goes on to say that 'this is obviously in pronounced contrast with some of the other sex chromosome disabilities such as Klinefelter's syndrome'. This is another misapprehension. Since 1968 we have been conducting a longitudinal study of growth and development on children with sex chromosome abnormalities, including 19 boys with the sex chromosome constitution 47,XXY, ascertained by population screening and hence free of ascertainment bias. Three of these boys have verbal scores of 130+ on the Wechsler intelligence scale for children, as has one of four referred cases, so they may well proceed to academic careers. While it is true that the group as a whole shows a small but significant lowering of intelligence quotient compared with controls, there remains a relation between the child's cognitive ability and social class, as reflected in the occupation of the father.²

References

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