methylprednisolone in doses of 30 mg/kg/day for three
days, 20 mg/kg/day for four days, and subsequently 10, 5,
and 2 mg/kg/day for one week each, respectively, followed
by 1 mg/kg/day until their haemoglobin concentration
reached 11 g/dl, as described previously in the treatment of
childhood acquired aplastic anaemia. Haemoglobin
reached this concentration in 34, 62, and 194 days,
respectively.

Liver and spleen became normal in size, with rises in
leucocyte and platelet counts and haemoglobin concen-
trations to normal, a decrease in reticulocyte count, and
disappearance of normoblastae in the first two cases
and improvement in the third child. The patients’ plasma
haemoglobin concentration and alkaline phosphatase
activity decreased to normal, with normalisation of haptog-
lobin concentrations. Their bone marrow became nor-
mocellular as studied by needle aspiration, but their bones
have not been influenced by treatment yet according to
findings on x ray film.

Although currently one child could only detect light and
still had mild exophthalmus and all had macrocrania, their
growth and development were appropriate for their ages.
The two younger cases still required 2.5 mg prednisone
daily and the third was currently on intravenous treatment.
With the exception of Cushingoid appearance during high
dose administration, they did not have any side effects of
treatment with corticosteroid, such as hypertension,
hyperglycaemia, or growth retardation.

I would also like to question the laboratory findings of
the authors’ second case, who had a normal (or raised)
haptoglobin concentration (5 mg/dl), despite pronounced
plasma free haemoglobin (125 mg/dl), which does not
agree my findings or expectations.

References
1 Dorantes LM, Mejia AM, Dorantes S. Juvenile osteopetrosis: effects on blood and bone of prednisone and a low calcium, high
2 Özsoylu Ş, Coşkun T, Minassazi Ş. High dose intravenous glucocorticoid in the treatment of childhood acquired aplastic

Diamond Jubilee issue

Sir,
The Diamond Jubilee issue of the Archives provided
fascinating accounts of those who over the years have
guided it to its present state of eminence as a paediatric
journal. Three citations were omitted—namely, those of
the present editors Roy Meadow and Bernard Valman and
the associate editor Malcolm Chiswick. While we recognise
and respect their modesty, we should not let the occasion
pass without acknowledging the very important part
which they have played in maintaining and enhancing the
position of the Archives. To Roy Meadow, who will shortly
be giving up the senior editorship, we owe a particular debt
of gratitude.

JOHN FORFAR
British Paediatric Association,
5 St Andrews Place,
London NW1 4LB

Working party on cystic fibrosis

Sir,
In Dr Jackson’s synopsis of the recent report of the British
Paediatric Association working party on cystic fibrosis
mention is made of the proposal ‘that there should be one
centre with from 50 to 100 patients in most regions’.1 In
some National Health Service regions it is clear that more
than one cystic fibrosis centre will be needed so perhaps
the proposal should be amended to ‘at least one centre
with from 50 to 100 patients in most regions’. The staffing
levels suggested for a clinic with 50 patients should, of
course, be increased pro rata for larger clinics.

Reference
1 Jackson ADM. Working party on cystic fibrosis. Arch Dis Child

JOHN A DODGE
Chairman,
BPA Working Party on Cystic Fibrosis