either before or during the period of immunosuppression does not necessarily confer protection. This is illustrated by two of our patients.

Case reports

Case 1. A boy, aged 3 years 5 months, first presented with a history of a progressive petechial rash. Physical examination showed pallor, bruising, and hepatosplenomegaly. A bone marrow aspirate confirmed a diagnosis of acute lymphoblastic leukaemia. We were unable to obtain a history of chickenpox infection and viral titres were negative for varicella zoster virus. He was started on chemotherapy. After 18 months of treatment he was admitted with shingles affecting the ophthalmic division of the right fifth cranial nerve. He had a full course of acyclovir and recovered well. The titre for varicella zoster was less than 16. He was then restarted on maintenance chemotherapy but returned four months later with a severe illness associated with a typical chickenpox rash. He was again treated with acyclovir, and at the end of this illness his varicella zoster titre had risen to 128.

Case 2. A 4 year old boy presented with a short history of bruising, pallor, and lethargy. A diagnosis was made of acute lymphoblastic leukaemia. He had had a chickenpox illness during the first year of life and shingles six weeks before the onset of his acute leukaemia. Physical examination showed scarring in the right lumbar region consistent with shingles. Varicella zoster titre was negative. He was started on chemotherapy but had a relapse of his leukaemia two and a half years later. At this time his varicella zoster titre was 1 in 16. He was restarted on chemotherapy and three months later developed chickenpox with a typical rash which was managed successfully with acyclovir. He developed another mild bout of chickenpox two and a half years later, six months after completing chemotherapy.

These two patients illustrate the problems associated with varicella zoster infections and the difficulty in assessing immune state. It is therefore necessary to be vigilant and protect immunosuppressed chickenpox contacts with zoster immunoglobulin even in the presence of a history of exposure.

Reference

[1] Campbell AGM. Immunisation for the immunosuppressed child. *Arch Dis Child* 1988;**63**:113–4.

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The highly talented child

Sir,

I was most interested to read the article by Dr Lask, but wish to take issue with him on one point. In the first paragraph he comments 'a 12 year old studying for an honours degree at Oxford University is clearly misplaced.' I fear that Dr Lask is falling into the trap of confusing gifted and highly gifted children. I agree that, if a child has an IQ of 'only' 140 or 150, she would be misplaced at such an institution at such an age. Many researchers have found, however, that the highly gifted, that is with an IQ of 170 and over, are peculiarly handicapped in the true meaning of the word: they have learning and social difficulties and are children with special educational needs.

In a famous experiment at Harvard, several children with exceptionally high IQs were admitted as young as 12, and in the report following their graduation the principal, Professor Eliot, stated that these students had shown fewer psychological problems, been happier, studied better and more effectively, and shown just as good results in their examinations as the ordinary students. He felt that the experiment had been a great success.

In the Stanford University's Longitudinal Studies of Giftedness, it was clear that if a gifted child was allowed full freedom to progress at his or her own rate he or she achieved their full potential and there were no psychological 'hang-ups' to sort out later. It has also become clear that, contrary to popular misconception, the highly gifted do not burn themselves out early, but continue to show superior mental powers right through into old age—as, indeed, one would expect.

Reference

[1] Lask B. The highly talented child. *Arch Dis Child* 1988;**63**:118–9.

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Conductive education for motor disorders

Sir,

As a research orientated physician and the father of a baby with cerebral palsy I would like to comment on the recent controversy about conductive education, which you have recently highlighted in your journal.[1 2] Dr Beach suggests that the parents of children who are severely handicapped or who are making only slow progress are drawn towards such 'alternative forms of treatment' because of suggestions by 'family and friends, professionals, parents' groups, or by the media'.[1] In some instances this may well be true, but I suspect that most parents do so, at least in part, because they have come to realise that their children's future is being compromised by the sad limitations of our health service. Should parents really be expected to accept one or two hours physiotherapy per week (in some instances not even that) as being sufficient for their children? What would you do? No parent would dispute Dr Beach when he suggests that 'teams of dedicated professionals' look after their children.[1] The rub is that there are simply not enough of them to go around! While there are justifiable doubts about the value of conductive education, I fear that there can be no doubt that the British system of care for children with cerebral palsy is grossly underfunded, and I cannot