but rather to early-normal puberty in the majority of girls.\(^1\) One wonders why Dr Leiper did not analyse in more detail the growth and development of the well defined group of girls who attained menarche and instead formed a selected group with evidence of early pubertal maturation.

Interestingly enough, the growth pattern of the girls followed to final height who were reported in Dr Leiper’s article, agrees very well with the results presented by us.\(^2\) Dr Leiper and coworkers do not analyse the growth data of the 55 girls who attained menarche. In our study the average height decreased from \(-0.5\) SD before puberty to a mean final height of \(-1.5\) SD. This loss in stature was due to a subnormal growth spurt.

Analysis of spontaneous growth hormone secretion during 24 hours indicates that girls treated for acute lymphoblastic leukaemia, including cerebral irradiation, have severely blunted growth hormone secretion already before puberty (C Moell et al, unpublished data). Growth at that time, however, is normal.

The growth hormone insufficiency of these girls seems to be relative and manifests itself only when the increased demands for growth hormone during puberty cannot be supplied with. In patients who lack an adequate growth spurt the onset of early puberty will cause additional impairment of final height. In this respect we agree with Dr Leiper that precocious and premature puberty can be an important factor in contributing to short stature in girls treated for acute lymphoblastic leukaemia.

References


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Drs Stanhope, Leiper, and Chessells comment:

Unfortunately, the paper by Dr Moell and coworkers was received after our manuscript had been submitted. We agree with most of their findings but we wish to indicate several important differences.

Four of the 10 patients described in Dr Moell’s paper had received craniospinal irradiation and it is not appropriate to include these children in the analysis of peak height velocity without data on sitting height and subischial leg length growth velocities. Moreover, the fields for spinal irradiation in early childhood may well have included ovarian tissue. No data were given for the onset of puberty in the patients described by Dr Moell’s group. The fact that the patients were all girls is interesting, however, and supports our hypothesis for the difference in timing of the onset of puberty in normal girls and boys.\(^2\) We excluded patients who had developed early puberty soon after receiving cranial irradiation; as stated in our paper, mean age at treatment was 4-0 years (range, 1.4-7.8) whereas mean age for the onset of puberty was 8-8 years in the girls and 9-3 years in the boys.

Although menarche is an easy event to date precisely, it has little physiological meaning. Menarche does not usually indicate the onset of fertility and the mechanism of a uterine ‘withdrawal bleed’ is simple compared with the intricate endocrine events preceding an ovulatory cycle. We only used menarche retrospectively to correlate the timing of cranial irradiation and sexual maturation.

We agree with many of Dr Moell’s comments about the growth of children with acute lymphoblastic leukaemia treated with prophylactic cranial irradiation; the predominant loss in height of such children is during the pubertal growth spurt. Although sex steroids are synergistic with growth hormone, the onset of the pubertal growth spurt is contemporaneous to a large increase in growth hormone pulsatility and indeed growth during puberty correlates with growth hormone secretion.\(^2\) It is not surprising that the predominant impairment in the growth of children who have growth hormone insufficiency secondary to cranial irradiation is during the pubertal growth spurt.\(^3\)

References


Increasing medical burden of child abuse

Sir,

I share Drs Sharma and Sunderland’s concern about the increasing medical burden of child abuse.\(^1\) In Central Birmingham Health District, with 43,000 children aged up to 15 years, health visitors now attend over 300 child abuse case conferences annually. We too are experiencing an appreciable increase in referrals which subsequently prove to be unfounded. School and nursery staff have heightened awareness, but this has increased the rate of false positive referrals. It is well recognised that identified child abuse is more common in children from socially deprived backgrounds. Such children are also more likely to sustain accidental injuries. My concern is that an unexplained bruise found on the inner city child of inarticulate parents, socially distanced from professional staff, may be much more likely to result in a child abuse investigation than an identical bruise in the advantaged child of middle class parents.

The circumstances which lead families to abuse their children are complex, and not confined to particular classes of society. I cannot agree with Sharma and
Correspondence

Sunderland’s concluding paragraphs, which have political overtones and are largely unsupported by evidence. I find it offensive to read of ‘a subclass that can only better itself by sinking further.’ There is abundant evidence that parents, even in the most difficult circumstances, have high standards for their children and strive to achieve these. The concept of the cycle of deprivation has been vigorously challenged by those who stress that it is the structures of society, rather than individuals, which are most to blame for deprivation.

Biological factors may be important but I cannot see the relevance of lactating hamsters. Other mammals defend their young with vigour. I had considered satisfactory housing a basic human right. What ‘misuse’ of housing could justify restriction of parental rights? Thanks to AIDS, access to contraception is freer than it has ever been but this is unlikely to affect the fertility rate of biologically immature young people. On a global scale, the elimination of poverty has proved a far more effective contraceptive than the condom.

References


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Drs Sharma and Sunderland comment:

Communications after the publication of our paper on the increasing medical burden of child abuse1 have saddened us by confirming both the increasing suffering and also the increasing amount of medical time which is being diverted from sick children by this small minority of families. Although all demographic variables were represented, we could not refute the conclusion of others that most of the grievously maimed come from illegitimate and ill educated families.2 In Bradford, two thirds of proved abuse occurred in a small minority predicted to be at risk, and those receiving most attention from social workers and health visitors fared worst.3 We are aware of the authority which endows ‘basic human rights’ but are sufficiently aged parents to know that rights carry responsibilities. We have recently been asked by a teenage mother for help to attain two further pregnancies (in order to obtain more housing points), and, separately asked to advise a social worker who displaced a handicapped child from nursery because a stepfather had threatened to smash his baby’s skull if it wasn’t in the nursery within 24 hours. Hard cases require hard decisions. Reviewing unpleasant options caused us professional discomfort but this was nothing compared with the real pain endured by these children. It is no longer acceptable to blame ‘the structure of society’ nor is it acceptable to use our political beliefs to protect ourselves from examining received dogmas.

We are saddened that some professionals are still being sucked into the tempting option of sacrificing the child for the greater good of the family. Paediatricians alone claim primary responsibility for the child’s case—general practitioners usually serve the whole family and are under ethical restraints on disclosure; health visitors are trained to think of the whole client group/family; social workers by training and statute consider the family as the primary client. Only paediatricians consider the child’s health as paramount and all else (including the family) as secondary to this.

We trust that our representatives will note these figures and press for greater resources. New strategies are needed to control this toll of violence. Child abuse has elicited spasmodic concern in the past and yet there is limited ability in the system to meet the needs of children in trouble, which is our paramount concern.

References