Non-accidental injury and copper deficiency

Sir,

Recent excellent articles by Dr Helen Carty and Dr J C L Shaw on non-accidental injury and copper deficiency correctly and clearly state that the court is not the right place to decide on the child’s welfare. I tend to agree with them. It appears that on both prosecution and defence sides winning a case if often of more importance than the truth. In achieving this each side tries to exploit the subtle nature of the medical evidence presented by the so called expert witnesses; this evidence has to be grasped and decided upon by the non-medical judges and juries—an almost impossible task. In my opinion the medical experts are as much to blame as the non-medical law profession in compromising the child’s welfare. Surely society and the medical profession as part of society, should not accept this unsatisfactory situation and should campaign for a system, perhaps away from the courts, which seeks the real truth and ultimately does justice to the child.

References


Good tolerance of pyrazinamide in children with pulmonary tuberculosis

Sir,

By adding pyrazinamide to the usual triple treatment consisting of rifampicin, isoniazid, and ethambutol, it is possible to reduce the duration of antituberculous treatment with equal efficacy. Despite recommendations paediatricians seem reluctant to prescribe pyrazinamide, probably because of fear of hepatotoxicity and effects on uric acid metabolism.

We have assessed the tolerance of pyrazinamide in 43 children with primary tuberculosis and abnormalities on chest radiography (principally hilar lymphadenopathy with or without parenchymal infiltration). The diagnosis of tuberculosis was confirmed by a positive Mantoux test (≥10 mm) and the finding of Mycobacterium tuberculosis in the children or their parents, or both. Mean age at diagnosis was 6 years (range 2 months to 15 years). Nineteen children were less than 3 years old.

Each morning, one hour before breakfast, during the initial phase all the children received rifampicin, isoniazid, and ethambutol at recommended paediatric doses and pyrazinamide (mean dose 23.3 mg/kg, range 20 to 37 mg/kg).

This regimen of four drugs was prescribed for two months in 38 children, three months in two, and four months in three children (because of initial resistance to isoniazid). The second phase of treatment consisted of daily rifampicin and isoniazid.

Plasma uric acid and plasma glutamic oxaloacetic and glutamic pyruvate transaminases were measured before initiation of treatment, one month later, and at the end of treatment with pyrazinamide. Plasma uric acid concentrations were normal before treatment (150-360 μmol/l). They increased slightly (360-450 μmol/l) in nine of the children (21%) and returned to normal when pyrazinamide was stopped. There were no signs of gout or arthralgias.

Liver enzymes were normal before treatment in 42 children and remained normal in 40. In two children transaminases increased (to three times normal values) at one month but returned to normal without modification of treatment. In one child the four antituberculous drugs were started just after viral A hepatitis; this did not prevent the normalisation of liver functions.

This paediatric study is in agreement with those carried out in adults and shows that pyrazinamide is well tolerated when used in doses <35 mg/kg/day even in infants. Furthermore, except in those five children with initial resistance to isoniazid, the duration of treatment was reduced to six months, which compares favourably with...