LETTERS TO THE EDITOR

Patient knowledge and compliance with growth hormone treatment

Editor,—There is no direct method of assessing compliance to natural sequence human growth hormone treatment and even urinary growth hormone measurements have proved unsuccessful. 1 What information is available concerns older treatment regimens of intra muscularly administered growth hormone, which are no longer used. 

Involvement of nurse is term daily in growth hormone treatment, being directly responsible for the care of children receiving growth hormone, although the approach to treatment, diagnosis, and monitoring of growth hormone treatment, is not annually based. Australia's Children with Growth Hormone Deficiency (GHD) registry. We would like to make the following points.


Audit of screening for congenital hypothyroidism

Editor,—Pharaoh and Madden conclude that administrative deficiencies were predominant in the response of health-care practitioners to the screening programme. 1 We are currently auditing the neonatal screening programme in the South East Thames region and would like to make the following points.

1. One of the most important features of well run screening programmes is ownership of the programme. At present in many districts the opposite applies true. The programme involves several health-care practitioners at different stages of the programme (for example midwives, health visitors, paediatricians, and community paediatricians) but in many districts there is no one person nominated as responsible for the whole programme. In our survey of health professionals in all districts it appears that only 7% (one of 15) districts in our region had a nominated person in charge of the programme. Nominated naming individuals with overall responsibility for monitoring the programme (similar to immunisation coordinators) could improve administrative problems.

Continuous infusion of zidovudine in HIV related thrombocytopenia

Editor,—Continuous intravenous infusion of zidovudine was beneficial in children with symptomatic HIV infection. 2 However clinical trials investigated only oral treatment and none compared the oral and intravenous routes of administration. Here we report that HIV related thrombocytopenia, and other related symptoms developing while oral treatment was administered, may be corrected by continuous infusion of the drug.

Case report

A patient developed a symptomatic HIV infection at 4 months of age with hepatosplenomegaly, failure to thrive, and recurrent bacterial infections as the main symptoms. CD4 cell count was 0.130×109/l and the proliferative response to mitogens was depressed. Clinical and immunological improvement (CD4: 0.450×109/l) was achieved by 150 mg/m2/6 hours of oral zidovudine (daily dose: 24 mg/kg). At 12 months of age the child presented with haemorrhagic symptoms and a platelet count of 10×109/l. Platelet bound IgG reactive with specific glycoproteins (gp11b-gpIIIa) and circulating platelet antibodies were detected. The number of megakaryocytes was normal. Symptomatic thrombocytopenia persisted despite immunoglobulin treatment. A response was obtained with high doses of oral prednisolone (3 mg/kg/day), but several relapses were observed as soon as the dose was slowly tapered off. At 18 months of age a continuous infusion of zidovudine, 1 mg/kg/hour, was initiated via a catheter using a lightweight portable infusion pump and administered over a month (figure). An overall clinical improvement was noted with regression of the hepatosplenomegaly. The platelet counts remained within normal values despite the discontinuation of the steroid treatment. In addition, lower clinical tests initially improved and P24 antigen became undetectable. The continuous infusion was well tolerated without neutropenia or