LETTERS TO THE EDITOR

Response to venepuncture for monitoring in primary schools

EDITOR,—We welcome the commentaries that followed our paper that was published in May.1 We think, however, that we need to clarify some of the points made in these commentaries to represent the views of the team members.

The last sentence of our paper can be easily misinterpreted as conveying the idea that venepuncture is ethically acceptable if the scientific merit of the question is important and the methodology of the study is sound. We hope that the readers will be convinced after reading our paper that, in the conduct of the study, it was made sure that information was available to the children’s parents in the study, that discomfort and the potential risks to the participants were minimal or negligible, and that parents and children were free to decide whether they wanted to participate in the study and free to withdraw from the study at any time, even after signing a consent form.

The scientific merit of the research is an important criterion to consider in addition to honest information, minimal distress to participants, and freedom to withdraw from the study at any time.

Professor Cockburn’s commentary may be interpreted as if we were challenging the Department of Health’s Health Authority arrangements. We were relieved by Professor Hull’s clarification that in experienced hands, venepuncture is a minimal risk procedure. One of our three phlebotomists had a very high rate of technical failures. We have learnt the lesson. For our main study we have made clear to the veneseters that they will have to spend some time training and the amount of training will be determined by the senior chief medical laboratory officer of the department of haematology with whom we are collaborating.

Armed with the results of the pilot study we submitted a protocol to include venepuncture in our main study to ethics committees in England and Scotland. We were relieved to find that 25 out of the 26 ethics committees approved our request; one is still processing our application. Incidentally, only one of the ethics committees queried the gift of a T-shirt as a show of appreciation to the children and most of the headteachers collaborating with our study were supportive of this element of the study.


Octreotide treatment associated with adrenal suppression and poor feeding

EDITOR,—Octreotide, a long acting somatostatin analogue, is increasingly used to stabilise infants with hyperinsulinaemia before surgery, or even in long term control of hyperinsulinaemia.1 It has few reported side effects in this group of patients.2 I write to report probable association of the use of octreotide with potentially severe adrenal suppression and with the less dangerous, but important problem of refusal of oral feeds.

Case report
A boy was born of consanguineous parents at 35 weeks’ gestation weighing 1500 g. Hypoglycaemia was noted on the first day of life with increasing glucose utilisation to >12 mg/kg/minute. Investigations on day 8 revealed low free fatty acid and branch chain amino acid, normal growth hormone, and high insulin concentrations at the time of the hypoglycaemia. A diagnosis of hyperinsulinaemia was made and niessidoblastinosis (pancreatic ductal dysregulation syndrome), was confirmed on day 90 at 95% pancreactectomy resulting in subsequent normoglycaemia at six months’ follow up.

Plasma cortisol was 56 nmol/l at the time of hypoglycaemia on day 8. This initial response was thought to be due to the immaturity of the infant. The long acting somatostatin analogue, octreotide, was commenced on day 10, 4.5 g/kg/day along with physiological replacement doses of hydrocortisone. The predose 9 am plasma cortisol concentrations remained constantly low (56, 21, 56, 42, 14 nmol/l) until the time of surgery and cessation of octreotide and then rose to 489 nmol/l within 48 hours and remained normal subsequently.

The baby fed extremely poorly requiring nasogastric feeds till day 60 when a trial of diazoxide was commenced and the octreotide withdrawn. The baby fed well for eight days until diazoxide related heart failure supervened and octreotide was restarted at which point nasogastric feeds were once again required. Octreotide was withdrawn post-operatively and immediately the child again took oral feeds.

The feeding difficulties and suppressed plasma cortisol concentrations in this child seem related to octreotide treatment. Somatostatin suppresses many peptide hormones and has a well established use in nesidioblastosis, sometimes for long periods with few reported side effects.3 Its use has been explored in pituitary Cushing’s syndrome with varying success.4 5 Suppression of appetite has been reported in patients on Safety of Medicines in one previous adult case but there have been no previous reports of hypoglycaemia.

Aetiology of childhood leukaemia

EDITOR,—The review by Taylor on immuno- genetics and the aetiology of childhood leukaemia,1 refers to the possible role of environmental factors, including infection, on the incidence of this disease. We are concerned that the mortality rate due to leukaemia rose by 4-5% annually in Great Britain between 1911 and 1959 is cited.2 Interestingly, 1911 is the year in which the threat of tuberculous cattle to human health was first raised by the British Royal Commission on Tuberculosis. This led to an increased use of preventive measures, initially pasteurisation of milk and subsequently eradication of infected cattle.

Before that time, infection of neonates by the bovine tubercle bacillus (Mycobacterium bovis) was a common event but most infections resolved spontaneously and appeared to afford protection against pulmonary tuberculosis of human origin later in life. Accordingly BCG vaccine, produced from M bovis and originally given orally to neonates, was intended to mimic this natural milk borne infection.

Some authors have claimed that BCG vaccination leads to a reduction in the incidence of leukaemias and other childhood cancers though others refute these claims. A re-evaluation of these reports revealed that BCG showed a significant protective effect only when it was given neonatally and in regions where protection against tuberculosis was also demonstrable.3 One explanation of this claimed effect is that BCG vaccination enhances the ability of cell mediated immune reactions to remove tumour remnants from which cancers might otherwise arise.4 It is therefore possible that natural infection by M bovis or its artificial analogue, BCG vaccination, in infancy might afford protection against leukaemia. This hypothesis could be tested in regions or countries that are undergoing changes in BCG vaccination policies.

1 Taylor J. Arch Dis Child 1994; 70: 553-555.


4 J K WALES Department of Paediatrics, Sheffield Children’s Hospital, Sheffield S10 2TH


8 BPA, 1992.

95% pancreactectomy for subsequent normoglycaemia at six months follow up.

Cough— but is asthma?

Editor,—Dr Sheila McKenzie has suggested that cough without wheeze should not be classified as asthma unless there is evidence of airway lability.1 In practice, chronic persistent cough is most troublesome in preschool children who cannot reliably perform standard tests of lung function.

A study of 60 children under 6 years with chronic cough showed that 63% of those aged 3 years or less had at least one positive reaction to skin testing with inhaled allergens (57% for house dust mite) compared with 75% of children with classical asthma and 10% of children without respiratory symptoms.2 Chronic cough, like wheeze, was usually worse at night (75%), precipitated by exercise (85%), and associated with nasal discharge (70%) or sore throat (32%).

The findings are consistent with 83% of children reported improvement or no cough at all but 25% developed recurrent wheeze as well as cough. It was difficult to assess response of cough to treatment because of the tendency to spontaneous resolution.

Cough alone may just be a feature of the viral upper respiratory infection which can also induce wheeze in asthmatic children or it may be a manifestation of airway inflammation triggered by hypersensitivity to inhaled allergens such as house dust mite. Although most children with chronic cough do not have asthma, there is no reliable way of identifying those who eventually develop definite bronchospasm. For persistent cough a trial of inhaled β agonists or inhaled steroids is logical and potentially less harmful than other common approaches like antihistamines, or even surgical ear, nose, and throat procedures.

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Growth standards for infancy

Editor,—We fully endorse the views of Wright et al on the need to develop new growth standards for infancy.3 The comparison of their Newcastle data with widely used standards4 and with the Cambridge Infant Growth Study illustrates this need succinctly. The Cambridge study is not, however, confined to breast fed infants. Although a high proportion (90%) were initially breast fed, this declined to 65% by 12 weeks, 54% by 24 weeks, and 18% by 1 year. Throughout most of the first year, the weights of infants breast fed to at least 24 weeks were similar to those bottle fed from 3 weeks. Both groups showed an increased weight gain compared with standards in the first six months, followed by a more marked relative decline, with only the breast fed boys showing a slight slower growth rate compared with those bottle fed. At 1 year, the mean (SD) weights were: boys breast fed (n=54) 9.79 (0.93) kg, bottle fed (n=35) 9.93 (0.97) kg, girls breast fed (n=59) 9.17 (0.81) kg, bottle fed (n=34) 9.18 (0.80) kg, and the Z scores5 were -0.4, -0.2, -0.5, and -0.6 respectively. Weaning practices are at least as important as mode of milk feeding. Energy intakes during and after weaning are lowest now compared with those in the second six months compared with those bottle fed. At 1 year, the mean (SD) weights were: boys breast fed (n=54) 9.79 (0.93) kg, bottle fed (n=35) 9.93 (0.97) kg, girls breast fed (n=59) 9.17 (0.81) kg, bottle fed (n=34) 9.18 (0.80) kg, and the Z scores5 were -0.4, -0.2, -0.5, and -0.6 respectively. Weaning practices are at least as important as mode of milk feeding. Energy intakes during and after weaning are lowest now compared with those in the second six months.

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