LETTERS TO THE EDITOR

Prevalence of behaviour disorders in low birthweight infants

EDITOR,—We wish to comment on some methodological and conceptual ambiguities in the report by Pharoah et al on behaviour disorders in low birthweight infants.1

First, in their methods section, dealing with the assessment of hyperactivity, the authors refer to ‘the Conners’ scale’ and do not mention the Conners teacher scale. The Conners paper to which they refer does not cite any reference to the teacher scale. Thus, the use of the Conners teacher scale is unreported and unrefereed. The Conners teacher scale does not have the same scoring norms as the Conners parent scale and the Conners teacher scale, nor is the scoring method the same. The authors also state that the Conners teacher scale has been used in a number of studies, but this is not the case. The Conners teacher scale has not been used in any of the studies cited by the authors.

Second, the authors fail to define their criteria for the diagnosis of hyperactivity. The authors state that the main criteria for the diagnosis of hyperactivity are ‘the presence of at least 17 symptoms of hyperactivity or aggression’ and that ‘children with fewer symptoms were not diagnosed’. However, these criteria are not sufficient to diagnose hyperactivity, as is evident from the findings of the study. The authors also state that the Conners teacher scale has been used to assess hyperactivity in a number of studies, but this is not the case. The Conners teacher scale has not been used in any of the studies cited by the authors.

Finally, the authors fail to mention the use of the Conners teacher scale in the Conners’ scale and should have cited Taylor and Sandberg’s (1984) study, which found a significant association between the Conners teacher scale and the Conners parent scale. The authors also state that the Conners teacher scale is a more sensitive measure of hyperactivity than the Conners parent scale, but this is not the case. The Conners teacher scale is not more sensitive than the Conners parent scale, as is evident from the findings of the study. The authors also state that the Conners teacher scale is a more specific measure of hyperactivity than the Conners parent scale, but this is not the case. The Conners teacher scale is not more specific than the Conners parent scale, as is evident from the findings of the study.

Studies on the cure rates in acute lymphoblastic leukaemia in children from urban and rural areas

EDITOR,—Acute lymphoblastic leukaemia (ALL) is an acute leukaemia that is characterized by the presence of at least 10% blasts in the bone marrow. The disease is usually divided into two subtypes: ALL-L1 and ALL-L2. The cure rates for ALL-L1 are generally higher than those for ALL-L2. The cure rates for ALL-L1 and ALL-L2 are 80% and 50%, respectively.

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Renal scarring after acute pyelonephritis

EDITOR,—Dr Jakobsson and colleagues have confirmed the value of technetium-99m dimercaptosuccinic acid (DMSA) imaging in urinary tract infection (UTI) in children both on initial presentation and follow up.1,2 The definition of DMSA abnormality used in Jakobsson’s report was ‘one or more areas of decreased cortical uptake with or without preservation of the cortical outline’.3 We therefore disagree with the authors’ assertion of the detection of renal cortical defects; however, we feel that the apparent 37% incidence of renal scarring following an episode of acute pyelonephritis in their study is over pessimistic.

We feel it is extremely important, when describing DMSA abnormalities, to state whether the abnormality is associated with or without loss of the normal cortical outline.4 The definition of DMSA abnormality used in Jakobsson’s report was ‘one or more areas of decreased cortical uptake with or without preservation of the cortical outline’.3 We therefore disagree with the authors’ assertion of the detection of renal cortical defects; however, we feel that the apparent 37% incidence of renal scarring following an episode of acute pyelonephritis in their study is over pessimistic.

We found a relatively high proportion of children presenting with a first documented UTI who had reduced uptake on DMSA but with preservation of the cortical outline.5 In the majority of patients, these changes resolved completely; however, we have anecdotal evidence of these changes persisting up to 36 months after an episode of UTI.

There is no doubt that DMSA imaging will enable the development of a more complete understanding of the natural history of UTI, however, if as is likely, this imaging modality...