


**Toledo type brachylomyia**

**EDITOR,** I read with interest the paper by Grain et al dealing with the first UK case of a type of brachylomyia (short trunk) which is associated with both peripheral corneal punctate opacities only seen by slit lamp and a qualitative abnormality of glycosaminoglycans (chondroitin sulphate).1

These data confirm our previous findings in four siblings with this autosomal recessive condition.2 We agree with the authors’ statement that these cases represent a distinct type of spondylar dysplasia. Natural history, physical examination, and ophthalmological, radiographic, and biochemical findings in the case reported by Grain et al coincide with those of our cases, except for two points. First, some of our cases had irregular chondroscoliotic ossification. Second, advanced bone age was not present in our cases and this may explain why final adult height in our male cases (3–10th centile) was not as short as the one predicted for the case reported by Grain et al (3rd centile).

As stated by the authors, this disease may be a currently unrecognised cause of short stature. We have suggested for the diagnosis of this brachylomyia, type I, that a slit lamp examination as well as detailed glycosaminoglycan studies should be performed as routine procedures.4 The latter test is currently available only in some laboratories, but it is of crucial importance for the diagnosis of brachylomyia type I. As autosomal recessive and autosomal dominant patterns of inheritance are involved in the four types of brachylomyia,1 the diagnosis among them will require an adequate clinical management of the patients and will give further support for adequate genetic counselling.

Present efforts in this type of brachylomyia should be directed to DNA studies and among the candidate genes one should include those involved in glycosaminoglycan metabolism. Sequencing and cloning of the gene for brachylomyia would allow a more precise diagnosis and genetic counselling for this condition.

**SERGIO TOLEDO**

Endocrine Genetic Unit, Department of Medicine, University of Sao Paulo School of Medicine, Av Dr Arnaldo 455, 5th edf-01246-903, Sao Paulo, Brazil


**Acyclovir in chickenpox**

**EDITOR,** Virological evidence for the reactivation of chickenpox contracted in infancy has recently been documented and related to the immune status of the host.1 Secondary attacks of chickenpox and early reactivation as zoster have been reported after the treatment of normal children with chickenpox suggesting that the immune response may be impaired after acyclovir treatment.2 We report the case of severe primary varicella infection in an infant who should have been protected by passive maternal antibody. His mother had been treated with acyclovir for chickenpox before delivery.

A 25 year old woman presented at 38 weeks gestation with a vesicular rash. The diagnosis of chickenpox was confirmed by the detection of specific IgM antibodies to varicella zoster virus and she was treated with acyclovir 800 mg five times daily for seven days. Nine days after the development of the rash she delivered a healthy boy. Six days after delivery he developed a vesicular rash and fever, and varicella zoster virus was detected in vesicular fluid. He was successfully treated with a five day course of acyclovir (100 mg 5 times daily).

This infant was born nine days after her mother developed chickenpox and, in accordance with current guidelines for the UK, he did not receive passive immunity globulin.3 We postulate that the use of acyclovir to treat the mother’s infection may have affected her immune response to the virus leading to reduced passive transfer of immunity to her fetus. When he was born he was at increased risk of varicella infection, which he subsequently developed. This case highlights concerns over the effect of acyclovir on the immune response to chickenpox and also suggests that the present guidelines for passive immunisation against varicella zoster virus may leave a proportion of infants born to mothers treated with acyclovir at unnecessary risk.

**PETER J ENKES**

JUDITH BREUER

Department of Virology, Royal Hospitals NHS Trust, 37 Ashfield Street, London E1 1BB


**Expulsion of ventriculoperitoneal shunt tubing**

**EDITOR,** A baby girl of 18 months was admitted to our unit on September 8, 1992 with a two week history of irritable baby, vomiting, and refusal to sleep. She had a fever of 38.5°C and a lumbar puncture showed cerebrospinal fluid protein of 3.65 g/l, 750 polymorphonuclear leucocytes/mm³ of cerebrospinal fluid, and Gram positive cocci on staining.

A diagnosis of pneumococcal meningitis was made and the child was treated with triple chemotherapy: penicillin, sulphadimidine, and chloramphenicol as was routine in 1982. She remained critically unwell and developed a third and sixth nerve palsy. Physical examination was unhelpful. There seemed to be no area of local tenderness or guarding. She continued to eat well and her bowels moved normally. Urine culture and analysis was negative and a plain abdominal radiograph failed to reveal any abnormality. The apparent abdominal pain that the child was suffering persisted intermittently for several weeks and she was reviewed and examined on several occasions. No clinical evidence of organic disease was elicited. After approximately eight weeks of intermittent symptoms a chest X-ray was reported to show a small new opacity in her stork which was clearly the distal portion of the ventriculoperitoneal shunt.

I am unaware of any reports of this particular complication of ventriculoperitoneal shunting.

**I L SWANN**

Department of Child Health, Burnley General Hospital, Gorton Avenue, Burnley BB10 2PQ


Infant length measurements

**EDITOR,** Like Professor Frank Falkiner,1 I was interested to read Dr Doull’s article on the reliability of infant length measurement,2 though a little disappointed to find no reference to the Neonatologist—an instrument for measuring crown-heel length in infancy designed and written up by Bob Holding (from Holtain Ltd) and myself 24 years ago3 in the Archives. This instrument, which, provided it was correctly used and inserted, was given to the technique in the training of observers with the neonatometer,95% of all observations of crown-heel length were likely to lie between plus and minus 3–4 mm of the true value.4 These represented accurate, length and reliable measurements. The constant pressure pad fitted to the number counter, allowing it to automatically lock, added particular precision. We also showed that mothers were well able to hold the head.

But a good reliable instrument is one thing, it is quite another to convince people of the value of length measurement in infants. Along with weight and head circumference, length is important—not only for the more immediate assessment of growth status but also to help evaluate a problem of growth in an older child by looking back at earlier measurements.

**D P DAVIES**

Department of Child Health, University of Wales College of Medicine, Heath Park, Cardiff CF4 4XX

