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The editors will decide, as before, whether to also publish it in a future paper issue.

Calibration of the paediatric index of mortality in UK paediatric intensive care units

Pearson et al. should be congratulated on successfully collecting the data required for calculating the PIM Score on the 7253 children admitted to 5 UK paediatric intensive care units (PICUs).1 It is reassuring to note that the authors did not find any systematic differences between these five units in terms of their standardised mortality ratios. Leaving aside the controversies involved in cross country comparisons, it is further pleasing that they appear to conclude that mortality following admission for paediatric intensive care in 1994–95 was less than it was in 1994–95. The current results imply that the children who have survived following treatment in these 5 PICUs than were predicted by the 1994–95 PIM derivation model. Before this can be considered a major clinical advance, it is important to consider the health status of the additional survivors. Very different conclusions might be drawn if the additional children who survived have a very good health status than if they have a very good health status.

The United Kingdom Paediatric Intensive Care Outcome Study (UK PICOS) was set up in paediatric intensive care units (PICUs).2 It is reassuring to note that the authors did not find any systematic differences between these five units in terms of their standardised mortality ratios. Leaving aside the controversies involved in cross country comparisons, it is further pleasing that they appear to conclude that mortality following admission for paediatric intensive care in 1994–95 was less than it was in 1994–95. However, it is important to consider the health status of the additional survivors. Very different conclusions might be drawn if the additional children who survived have a very good health status more than 10%, morbidity or health status may be a more important outcome of paediatric intensive care than mortality. UK PICOS is currently collecting health status measurements of children who survive following admission for paediatric intensive care in a representative sample of 21 UK PICUs. By seeking to differentiate between the survivors of paediatric intensive care, UK PICOS may lead to a risk adjustment method for health status in addition to mortality. Furthermore, UK PICOS has the potential to provide the methodology to enable cost effectiveness studies to be set up in paediatric intensive care. In the longer term this will allow organisational structures, service management, and new interventions in paediatric intensive care to be evaluated in a more rigorous manner than at present. Further details of UK PICOS are available at www.shef.ac.uk/~scharl/ukpicos.

G Parry
School for Health and Related Research, University of Sheffield, Regent Street, Sheffield S1 4DA, UK
G.parry@sheffield.ac.uk

S Jones
Project Manager, UK PICOS
M Simic-Lawson
Intensive Care National Audit & Research Centre
London W1C1H 9HR, UK

References

Calibration of the paediatric index of mortality score for UK paediatric intensive care

Pearson and colleagues have presented data highlighting the use of the paediatric index of mortality (PIM) score as a tool for auditing paediatric intensive care unit (PICU) performance.1 Whilst we would agree with the authors’ message that PIM has many advantages over other scoring systems, we feel that urgent calibration is needed before this tool is adopted as a benchmark for performance indication in the UK. PIM variables were developed predominantly from an Australian data set (one British PICU, Birmingham participated) over 1994–95; the data used in Pearson’s validation comes from five UK PICUs, including our own over the period 1998–99. PIM continues to discriminate well between death and survival reasonably well giving an area under the ROC curve of 0.840 (95% CI 0.819–0.853),1 marginally less than the figure of 0.90 seen in the original paper.1

However, from the 4 year period between development and validation the model is now recalibrating poorly, as evidenced by two pieces of information from Pearson’s study.

First, the overall standardised mortality ratio (SMR) is 0.87 (95% CI 0.81–0.94); this figure is remarkably concordant across 4 of the 5 PICUs. Second, from table 2, it is possible to calculate the Hosmer-Lemeshow statistic: chi-squared = 37.41, p<0.0001. This implies poor calibration, (good calibration traditionally represented by a p value >0.10).

The reasons for the loss of calibration are unclear. A possible, perhaps optimistic explanation is that UK units in the latter study were all “over performing” given that individual units demonstrated an SMR of between 0.83 and 0.89. However, it is unlikely that such a quantum leap in the quality of paediatric intensive care delivery has occurred over the 4 years between 1994–98, given that no major treatment breakthroughs or radical service reorganisation has occurred in this time.

More recent data from our PICU highlight the trend towards poorer calibration, where the PIM-derived SMR from 910 patients seen during the 2000 calendar year is 0.54 (95% CI 0.39–0.69). The authors acknowledge the shortcomings and state that a revised version of PIM will soon be available. However, recalibration is only worthwhile if a very broad sample of UK units participates. The UK PICOS study (paediatric intensive care outcome study) will attempt to address this, by collecting data used in the calculation of several scoring systems across the whole of the UK over a one year period commencing March 2001. From this study it is hoped that an optimal indicator of PIM performance will be derived.

M Tibby, J A Murdoch
Paediatric Intensive Care Unit, Guy’s Hospital, London, UK
Shane.Tibby@gstt.shades.nhs.uk

References

Authors’ reply

Dr Tibby and Dr Murdoch note that, in our study of paediatric intensive care units (PICUs) in the UK,2 PIM discriminated well between children who died and children who survived, with an area under the ROC curve of 0.84. However, they are concerned that PIM had “poor calibration” because the standardised mortality rate (SMR) in the UK units was 0.87 (95% CI 0.81–0.94)—that is, the actual number of deaths was only 87% of the number predicted by PIM. In fact, this figure is almost identical to the PIM SMR for all PICUs in Australia in 1997–99, where the SMR was also 0.87 (95% CI 0.81–0.92). It is very encouraging that PIM gives such similar results in Australia and the UK.

It is normal for SMRs to fall with time as intensive care improves, and for mortality prediction models to need recalibration. This has happened with PRISM,2 MPM1, and APACHE,3 as well as PIM. Despite Dr Tibby and Dr Murdoch’s reservations, the fact that the SMR has fallen evenly across both Australia and the UK suggests that standards of care have improved in PICUs in those countries in recent years.

Dr Tibby and Dr Murdoch point out that the Hosmer-Lemeshow test gives a low p value for...
PIM’s performance in the UK data. This test divides the sample into 10 groups, ranging from very low to very high risk of death, and compares the actual number of survivors and non-survivors in each group with the number predicted by PIM. Because PIM predicts too many deaths in the leading units in the UK, it follows that the number of actual deaths differs from the number predicted—so the Hosmer-Lemeshow p value is low. However, table 2 in our paper shows that the ratio of observed to expected deaths was similar across the 10 groups, so that the recalibrated model is likely to fit well. The fact that the Hosmer-Lemeshow test gives a low p value does not necessarily mean that the standard of care in the test PICUs differs from that in the units in which the model was derived.

The PICUs that contributed the data from which the PIM score was derived were all leading units that deliver a high standard of care, so the score reflects best practice in 1994–96 when the data were collected. We are recalibrating PIM using data from units in the UK and Australia, and the new model will be available this year. Unfortunately, the quality of paediatric intensive care is not uniform in the UK, and there is evidence that some units of paediatric intensive care is not uniform in the UK (PICOS). The UK should aim for best practice rather than being content with average practice.

**F Shann**
Royal Children’s Hospital, Parkville, Victoria 3051, Australia

**G Pearson**
Birmingham Children’s Hospital, Steelhouse Lane, Birmingham B4 6NH, UK

Gale Pearson@bhamchildrens.wmids.nhs.uk

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### Table 1

<table>
<thead>
<tr>
<th>Case</th>
<th>Preop FEV1 (%) of predicted</th>
<th>Postop FEV1 (%) of predicted</th>
<th>Long term follow up FEV1 (%) of predicted</th>
<th>Preop PVC1 (%) of predicted</th>
<th>Postop PVC1 (%) of predicted</th>
<th>Long term follow up PVC1 (%) of predicted</th>
<th>Number of years followed up</th>
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FEV1, forced expiratory volume in one second; PVC1, peak expiratory flow volume in one second.

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### Table 2

<table>
<thead>
<tr>
<th>Case</th>
<th>Operation</th>
<th>Local Chrispin-Norman scores Preop</th>
<th>Postop (6 mth)</th>
<th>Long term follow up (6 mth)</th>
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<td>RUL and RML</td>
<td>5</td>
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<td>4</td>
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</table>

Data are the Chrispin-Norman scores in the lung quadrant within which the patients had developed focal bronchiectasis and for which they underwent lobectomy (maximum score 8).

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### References


Long term results of lung resection in cystic fibrosis patients with localised lung disease

We have previously reported favourable short term outcomes following lobectomy in six children with cystic fibrosis and severe localised bronchiectasis (range 6 months to 6 years post-operation). Prior to surgery all had significant respiratory symptoms despite aggressive conventional treatment, including frequent courses of intravenous antibiotics. Computerised tomography and ventilation scans showed severe localised disease with little or no evidence for bronchiectasis elsewhere. Lung function was maintained or improved in all but one case from six months post-surgery, and all had improved symptoms. All children have now been reassessed at least four years postoperatively (table 1).

### Anti-neutrophil cytoplasmic autoantibody positive glomerulonephritis in monozygotic twins

Scant information is available concerning anti-neutrophil cytoplasmic autoantibodies (ANCA) associated disease in children, and very few cases of familial vasculitis have been reported in the literature. We have observed two monozygotic twins developing ANCA necrotising glomerulonephritis (GN). A 7 year old boy was hospitalised for normocomplementemic acute nephritis. Pericutaenous renal biopsy revealed idiopathic crescentic GN with negative immunofluorescence. Dialysis was started because of a worsening in renal insufficiency. Despite several courses of daily plasma exchanges combined with intravenous methylprednisolone and cyclophosphamide, there was no improvement; one year later, the boy received a cadaveric renal transplant.
Persistent proteinuria appeared four years after transplantation, when a renal biopsy revealed focal necrotising GN.

At the age of 10 years, the identical male twin was found to have microscopic haematuria and proteinuria of >1 g/24 h with normal renal function. Renal biopsy showed focal necrotising GN with 20% cellular and segmental crescents. Perinuclear ANCs were observed at a dilution of 1/160. The stored samples of the first twin were tested and pANCAs were detected by indirect immunofluorescence.

This second twin was given intravenous methylprednisolone and cyclophosphamide. The clinical picture was characterised by acute episodes resolving with repeated courses of methylprednisolone pulses.

ANC positivity in the second twin (also found retrospectively in the first twin’s serum) allowed us to classify the disease as a renal limited vasculitis expressed by necrotising and crescentic GN.

The HLA antigen profiles of the two boys are A3,11; B27,35; DR12; DQ1. Acute nephritis or urinary abnormalities were the initial onset symptoms in our patients. They occur in about 40% of children with ANCA associated GN.8 This emphasises the need for a precise diagnosis and aggressive treatment in such patients.9 ANCA should be sought in the presence of acute nephritis or persistent urinary abnormalities of unclear aetiology, and not only in children with frank vasculitis or rapidly progressive GN.

We believe this to be the first report of the recurrence of pauciimmune crescentic GN in a transplanted kidney in a child. Anti-rejection treatment with steroids and cyclosporine A seems to be a useful means of controlling disease flare ups.

Furthermore, as far as we are aware, this is the first report of pANCA GN in HLA-identical twins. The pathogenesis of ANCA-GN is unknown but likely implicates genetic and/or environmental influences.10

The onset of disease at different times in two identical twins seems to suggest a genetically determined susceptibility rather than environmental triggers. Review of the literature revealed few reports of familial vasculitis, with some evidence suggesting a genetic predisposition of the HLA class I antigens present in our twins (A11, B35), and antigen B35 alone have also been found in two families.11

In conclusion, a pANCA test should always be performed in children with acute nephritis of unclear aetiology; a diagnosis of ANCA GN should not preclude renal transplantation. HLA B35 may play a role in the pathogenesis of ANCA GN.

M. Giani, L. Andronio, A. Edefonti, Dept of Paediatrics, G. e D. De Marchi, Dept of Paediatrics, G. e D. De Marchi, Milan, Italy. 

References


Clicking ribs—a clinical sign of rib fractures

It is well recognised in non-accidental injury that some children who have rib fractures on x-ray have no external evidence of these fractures.2 The clinical features of rib fractures in children are often non-specific and may include local pain on motion, tenderness over the ribs and limping. However, there are three cases described recently in which the presenting feature of a child with rib fractures has been a clicking sensation of the affected ribs.

In conclusion, a pANCA test should always be performed in children with acute nephritis or persistent urinary abnormalities of unclear aetiology, and not only in children with frank vasculitis or rapidly progressive GN.

At the age of 10 years, the identical male twin was found to have microscopic haematuria and proteinuria of >1 g/24 h with normal renal function. Renal biopsy showed focal necrotising GN with 20% cellular and segmental crescents. Perinuclear ANCs were observed at a dilution of 1/160. The stored samples of the first twin were tested and pANCAs were detected by indirect immunofluorescence.

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In conclusion, a pANCA test should always be performed in children with acute nephritis of unclear aetiology; a diagnosis of ANCA GN should not preclude renal transplantation. HLA B35 may play a role in the pathogenesis of ANCA GN.

H Carty

Department of Paediatric Radiology, Royal Liverpool Children’s NHS Trust, Alder Hey, Eaton Road, Liverpool L12 2AP, UK

Lipid and glucose metabolism in HIV-1-infected children treated with protease inhibitors

The use of protease inhibitors (PIs) in patients with HIV-1/AIDS has been associated with peripheral lipodystrophy, hyperlipidaemia and insulin resistance. It is not clear whether all studies have been done in adults. The aim of this study was to evaluate the influence of highly active antiretroviral therapy (HAART) on serum levels of fasting triglyceride, total cholesterol, high density lipoprotein cholesterol (HDL), low density lipoprotein cholesterol (LDL), free fatty acids (FFAs) and glucose in twenty HIV-1 infected children treated during a minimum period of 18 months with an indinavir (HIV) or nelfinavir (NFV) containing regimen of HAART.

The lipid values were evaluated at two time-points: within the first month of HAART (“baseline values”) and after 18 months or more (range 18–24 months). Serum levels of fasting glucose was only evaluated at follow up.

In summary, we found an increase in serum levels of total cholesterol and LDL after PI use in HIV-1-infected children, as was previously observed in adults.1 However, in contrast with adults, a marked increase in HDL and normal glucose levels was observed.2 The total cholesterol/HDL ratio, fasting triglyceride and FFA levels remained stable over time.

To date, it has not been revealed whether these metabolic changes are the result of HAART or if HIV-1 infection itself is responsible. Hypertriglyceridaemia and low levels of total cholesterol, HDL and LDL have been detected in HIV-1-infected patients without prior antiretroviral therapy, especially in the late phase of the disease.3 Thus, the significant rise of total cholesterol, HDL and LDL in HIV-1 infected children may not only be attributed to the effects of HAART, but may be also partially be the result of a normalisation of pre-existing lipid abnormalities.

It is difficult to discriminate the metabolic effects of PIs from those of other antiretroviral drugs in this study. Most children received a combination of a PI, zidovudine, and lamivudine, which are also reported to cause lipodystrophy and lipid abnormalities.4 Eleven children were pretreated with zidovudine before the start of HAART. These children had significantly lower levels of total cholesterol and LDL at baseline than naive children, suggesting that zidovudine itself may have an effect on the lipid metabolism.

After these results we unfortunately have to conclude that HAART also effects the lipid and glucose metabolism in children.

We would like to thank I. Zwang and M. A. van Fessel for performing the laboratory analyses, W. C. J Hop for statistical advice, G. J. Brunning, F. Pistor, H. J. Schepers, and T. F W Wolfs for their co-operation.

M Vink, A M C van Rossum, N G Hartwig, R de Groot

Department of Paediatrics, University Hospital, NL-3000 GD Rotterdam, The Netherlands

References


Hepatitis B prevalence among Somali households in Liverpool

A cross sectional descriptive study was undertaken in the Liverpool Somali population in order to determine the prevalence of hepatitis B markers. Sessions were held at two health centres providing care for Somali households. A total of 439 subjects were screened, of whom 194 (43.3%) were children aged less than 15 years. It was found that 5.7 per cent of the study population were carriers of HBsAg, seven of 80 (8.7%) children born in the UK and aged 5 years or less had evidence of exposure to hepatitis B. Of their mothers only one was a carrier, one had anti-HBC antibody, and five were non-immune. The main reason that horizontal HBV transmission continues at an early age among Somali immigrants.1

The UK is one of the few western European countries which has chosen not to comply with the WHO recommendations for universal hepatitis B vaccination. This position has recently been defended,2 although no reference was made for the need to immunise high risk ethnic groups outside an antenatal screening programme. Evidence of previous hepatitis B infection in children is not uncommon among the Somali population in Liverpool. This has implications for screening of children who may benefit from immunisation. If screening of high risk groups and vaccination of susceptible

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children is not undertaken, this may result in unnecessary exposure of these children to hepatitis B infection.

B Brabin, N J Beeching, J E G Bunn, C Cooper, K Gardiner, C A Hart
University of Liverpool and Liverpool School of Tropical Medicine, Pemboke Place, Liverpool L3 5QA, UK; j.taylor@liverpool.ac.uk

Reference

Treating childhood hyperhidrosis with botulinum toxin type A
Recently there have been a number of published studies on the use of botulinum toxin type A for hyperhidrosis.1,2 These studies focus on its use in adults and we would like to highlight that it can also be useful in treating childhood hyperhidrosis. As in adults, hyperhidrosis can have considerable impact on quality of life in children. This is illustrated by a 13 year old healthy girl referred for treatment of hyperhidrosis. She had hyperhidrosis of the fingertips only. No adverse effect on grip strength or sensory function were observed. The cial effect of botulinum toxin lasted four months. Further injections were given to the finger tips and the area over the hypothalamic area. She reported improved quality of life with complete resolution of sweating during daily activities (in the absence of any other measures such as topical anti-perspirants). When questioned on her school work. She noticed grip strength during writing improved significantly. She was able to hold her pencil without inking smudging the paper because of sweating.)

Caring for Muslim Patients

Islam is the religion of one-fifth of humanity and, with an estimated population of 1.6 billion Muslims, Islam is the world’s largest religious minority group. There is, therefore, a need for a book that gives advice and guidance to non-Muslim healthcare professionals when dealing with Muslim patients and their families. This book is not just for healthcare professionals but for everyone who wants to understand the Muslim patient and their beliefs and needs. The reader will find information on the Muslim faith and way of life, including marriage, pregnancy, and the major causes of death in the Islamic calendar. There is helpful information on the role of family and community in the care of Muslims. The book focuses on the practical aspects of healthcare and provides a comprehensive guide to the unique issues faced by Muslim patients. The book is divided into nine chapters, each dealing with a different aspect of healthcare. There are also useful appendices on Islam and the Internet, which are paid to the Royal Medical Benevolent Fund. The authors have succeeded in providing a guide that is easy to understand and use. If you are caring for Muslim patients, this is a book that you should have on your shelf. The book is also a useful tool for healthcare professionals who wish to improve their understanding of Islam and its impact on healthcare.
high expectation for a strong potential in children. The two factors drove the research into childhood migraine many steps forwards. Unfortunately despite the huge amount of new knowledge on the subject and, possibly, the increased prevalence of headache and migraine in children, there is more need now than ever for an up-to-date publication on the subject. Until now, only two books on childhood headache and migraine are available on the paediatric bookshelf. The Classical books of Charles Barlow (Headache and migraine in childhood, Oxford: Blackwell Scientific, 1984) and that of Judith Hackaday (Migraine in childhood, London: Butterworth, 1988) remained the most recent sources of information and advice for practising paediatricians and general practitioners. Therefore, this book comes at an appropriate time to fill some of the gaps in the paediatric literature.

The book deals mainly with the diagnostic issues, differential diagnosis, and the management of childhood headache in a simple and practical way. Complex concepts and mechanisms were introduced and discussed with simplicity that made the reading of the book flow easily. Headache was introduced as a pain syndrome that has its own methods of measurement and management in the early parts of the book. The general direction of the book was determined, therefore, by the fact that 7 out of the 10 contributing authors been pain scientists, clinical psychologists, or child psychiatrists. Such an influence towards the psychology of pain has enhanced the quality of the book and enriched its value and contents. Therefore, the book provides the researcher on the subject of pain and headache a valuable reference to understand difficult issues in relation to pain measurement, impact of pain and headache on child’s life and also the management of headache including behavioural modification.

From the point of view of the practising general paediatricians who deal with children with headache in busy medical paediatric clinics, the book provides a good brief overview of the causes of headache, diagnostic assessment, and treatment. The use of simple data collection sheet would be very useful to assist the attending physician in establishing the diagnosis of the type of headache and also in identifying both the trigger and relieving factors. The editors propose, in two appendices, lengthy interviews of the child and the parents that may defy the practicability of the consultation. It would be more appropriate to the clinician if those interviews were short and direct. Also, diaries would be a useful tool to help understand the child’s headache by recording symptoms as they occur.

There is no doubt that this book will prove to be an important and useful resource for paediatricians treating children with headache. Other publications dealing with the practical issues and the organisation of headache services for children are also needed.

I Abu-Arafeh

Core Paediatrics and Child Health


Another textbook of paediatrics finds its way to market, to take its place alongside those already in print. In their introduction, Haddad et al write that they have written this for undergraduates and junior doctors undertaking their first paediatric post. The underlying concepts arise from prior collaborative work undertaken by departments of Child Health in Scottish Universities in response to the GMC guidelines contained in “Tomorrow’s Doctor”. This work, reported in Medical Education, provides a structure that gives uniformity of approach for each organ system and indeed the textbook is clearly and consistently laid out.

As with many other authors of textbooks, the authors start with an assumption that the layout of texts will influence learning. It is difficult to find any supportive evidence in educational literature and any research suggests that it is assessment rather than course material that drives acquisition of knowledge and reasoning skills. Nevertheless it seems reasonable to assume that those learning paediatrics should be able to choose from a selection of texts written and laid out differently. As such, it could be commended to students if they are considering the purchase of a textbook to support their learning, and I feel sure it will take its place in the “top five” of UK paediatric textbooks.

Although system based, the authors claim they have adopted a “problem oriented approach”. This does not match other books that start with clinical signs and symptoms; such a true problem oriented approach can be seen in Field et al’s book. This difference highlights the difficulty of writing a text for both students and practising doctors. Anecdotally, students, who seem to prefer topic based teaching while SHOs, may find a true problem based approach more suited to their needs. They do, nevertheless, include “Key problems”, and have useful sections that review underpinning science, such as “Essential background”. For the enthusiastic student who wishes to pursue any topic further, they have included “Beyond core” material and sections entitled “Highlights and hypot heses”.

At over 300 pages, it probably contains more than is needed at undergraduate level but could be seen as core and a suitable text for reference. SHOs might find its system based layout less helpful in their learning how to practice paediatrics, but it would be a useful starting point for revision for postgraduate exams.

Teachers need to look at evaluation from a different perspective. How should they evaluate material for students undertaking their course? Fundamentally, any text should support and not divert student effort from the learning objectives, and should help the teachers by providing them an agreed core curriculum. As a collaboration between Scottish departments of paediatrics, this book should not present a problem north of the border, but others will need to analyse it mindful of their own course objectives. As a tutor at Imperial College School of Medicine this would raise problems. Our main course objectives are that:

1. Students should acquire understanding of families, their structure and how children are supported within this.
2. Students should acquire the skills of history taking and examination of children along with the necessary communication skills.
3. Students should acquire a basic knowledge of common and important childhood diseases.

This textbook clearly supports the last objective but neither 1 nor 2, although it is only fair to say that this criticism could be levelled against other similar textbooks. This could be seen as an argument for radical redesign of all undergraduate texts to match more fundamental course aims rather than a “topic based” core curriculum, but such discussion is outside the remit of a book review such as this.

My one major criticism is that it divides up history taking and examination according to body systems. Development of these clinical skills must be the cornerstone of undergraduate education, and dissection of history taking and examination makes it a difficult text from which to teach these essential practical skills. Having said that, this book offers a clearly structured text for early professional education, and it will be interesting to see how it is received by the consumer, the medical student or doctor undertaking general professional training.

M D C Donaldson

References

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### Letters

**Break dancer’s lung**

Break dancing was at its peak of popularity in the 1980s, but evidently is still part of today’s youth culture. There have been several reports of injuries associated with this activity, although none recently. 1,2 While mainly of an orthopaedic nature, the injuries reported are quite varied. This is a report of a previously fit and healthy 16 year old non-smoking young man who was 5 foot 5 inches tall. He developed a right sided pneumothorax during an evening spent break dancing. He ignored the discomfort for a few days, and then after a visit to his general practitioner, a chest x ray confirmed the diagnosis. He required an admission he showed coarse facies, large tongue, diffuse exertional pain in both lower limbs, and delayed deep tendon reflexes.

Examination and lung function were normal and a CT chest scan revealed tiny subpleural bullae at the apex of the left lung. He was advised to avoid break dancing, although the chance of adherence to this advice was small. Two months later he had a further recurrence on the left side (during sleep) which was treated conservatively and resolved after 2 weeks. He then underwent a left thoracotomy (which revealed multiple bullae up to 1 cm diameter over the surface of the lung) and a pleurectomy from which he made a good recovery.

To my knowledge this is the first report of a spontaneous pneumothorax associated with any form of dancing. Presumably lying on his back with his legs fully flexed increased his abdominal pressure, and possibly combined with a Valsalva manoeuvre, this was enough to rupture one of the bullae. Although it was the presence of bullae that was responsible for the pneumothoraces, the risk (albeit small) of pneumothorax should now be added to the list of conditions associated with break dancing.

I would like to thank Dr Sinan Al-Jawad for looking after this patient during his acute pneumothoraces and Mr Peter Goldstraw for performing the surgery.

I M Balfour-Lynn
Consultant in Paediatric Respiratory Medicine, Royal Brompton & Harefield NHS Trust, Sydney Street, London SW3 6NP, UK.
i.m.balfourlynn@ic.ac.uk

### References


**Kocher Debre Semelaigne syndrome: regression of pseudohypertrophy of muscles on thyroxine**

Myopathy associated with hypothyroidism classically presents with proximal weakness, fatique, exertional pain, slowed movement, diminished deep reflexes, stiffness, myalgia, myoedema, and less commonly, cramps. Rarely, muscle enlargement is also seen, and the term Kocher Debre Semelaigne syndrome (KDS syndrome) is used. 1,2

We report the case of an 11 year old boy presenting with poor growth, mental retardation, diffuse exertional pain in both lower limbs, and progressive difficulty in squatting for six months. There was no family history. On examination he showed coarse facies, large tongue, athletic build, with height 110 cm and weight 22 kg. His IQ was assessed as 60, power in proximal group of muscle was Grade III, and calf muscles showed firm enlargement with delayed deep tendon reflexes.

Investigation showed normal haematology and renal function, electrocardiogram, and skull and chest x rays. Serum thyroxine was 72 nmol/L (n = 64–154 nmol/L), serum triiodothyronine was 1.8 nmol/L (n = 1.1–2.9), serum thyroid stimulating hormone = 10.0 mU/L (n = 0.4–5.0 mU/L) and serum creatine phosphokinase was 2246 U/ml (n = 35–145 U/ml). Muscle biopsy showed patchy atrophy, necrosis, and increased interstitial connective tissue without any fibre enlargement.

He was started on thyroid hormone (L-thyroxine) 0.1 mg per day and was followed up at monthly intervals. After six months of hormone replacement therapy his signs of hypothyroidism, associated myopathy, and hypertrophic calf muscles regressed. Repeat muscle biopsy revealed a decrease in interstitial connective tissue, atrophy, and necrosis with areas of muscle regeneration. Serum T3, T4, and TSH values also returned to normal.

Previous case reports of this variant of hypothyroid myopathy have described improvement of clinical features. 3 However, we found that maintenance of euthyroid state not only improved clinical features including the neurological manifestations of hypothyroidism, but also a marked regression of muscle enlargement. In our case we also demonstrated histological regression of changes in histopathology of hypertrophied muscle.

P Mehrotra, M Chandra, M K Mitra
Department of Medicine, B/127 Nirala Nagar, Lucknow, PIN 226020, India
Correspondence to Dr Mehrotra; punmell@yahoo.com

### References

BOOK REVIEWS

Child Mental Health in Primary Care

Over the school holidays, this book was left on my desk whilst I was away on holiday. During this time, my secretary photocopied two chapters for an anxious general practitioner, a health visitor, and a junior doctor borrowed it and when I finally got time to read it, the book was missing because our locality mental health worker had taken it home. Reviewers normally read books in pristine condition, this one was distinctly creased and dog-eared. It therefore goes without saying that this is an excellent book.

Knowledge of the psychological and psychosomatic disorders of childhood is not an optional extra for primary care teams and paediatricians. In primary care settings in the United Kingdom, 2%–5% of children brought to the general practitioner by their parents have mental health problems as their main complaint and 23% of children have a combination of both psychological and physical problems.

The Audit Commission has recently revealed the striking regional and local disparity in services for children with mental health difficulties. An important component of this variation is a tendency, in some districts, to refer all children, as fast as possible to a specialist. Inevitably this practice leads to long waiting lists, months of anxiety for parents, children's behaviours becoming more entrenched, families more dysfunctional, and the over investigation by doctors of non-organic disease.

This book will go a long way to equip practitioners with the basic skills and knowledge and, almost as important, the confidence to successfully manage problems at an early stage. This can only be good for children and their families. The book is written in a common sense, down to earth, easy to read way. It recognises the reality of the clinical situation. The chapters are short and contain useful case histories and amusing cartoons. The chapter headings are helpful and logical. This is a book for the busy professional who needs rapid access to help and advice.

The book takes a developmental approach. It is clearly divided into problems which occur at any age, following logically through the difficulties of the pre-school years, school years and adolescence. There is even a detailed chapter on treatment options for the truly enthusiastic professional.

Criticisms are few and far between. It is however disappointing that the whole range of multidisciplinary services for children which constitute community child health receive only scant mention. Families with children with emotional and behavioural difficulties are helped and supported by a range of agencies. The lack of emphasis on working with day nurseries, schools, the social services, therapists, and the voluntary sector, to name but a few, is a real omission. These services are often more important to parents than even the best of health professionals and have a vital role to play in the teaching of socially appropriate behaviour.

Primary care team members rarely pick up the phone to talk to a child's teacher or school nurse. Done with parental consent this exercise can bring a whole new dimension to a difficult family problem. The strategy was not mentioned even in the chapter on school refusal. Social services are acknowledged as the key agency in the protection of children but there is a disappointing lack of reference to their role of supporting children in need.

The book would also benefit from a chapter on what to do when all else fails. Every primary care team will look after a number of truly dysfunctional families. In these families, the children will always be presented as the “problem” but few of the eminently sensible suggestions in this book will work. The families normally fail to attend specialist appointments, but return time after time to the general practitioner's surgery.

These reservations are however minor. This book should be within easy reach of every general practitioner, health visitor, and paediatrician and they should buy the book instead of appropriating the reviewers copy!

Mary Mather

Congenital Hemiplegia

If you believe that congenital hemiplegia is a straightforward, unilateral motor disability then you need to read this informative book. On the other hand, if you appreciate the variety of motor difficulties and additional problems experienced by children with congenital hemiplegia, then you will value the practical guidance offered in this comprehensive review of a deceptively challenging disorder.

About 30% of children with cerebral palsy have a congenital hemiplegia. In around 40%, the hemiplegia results from periventricular haemorrhage or leucomalacia, whilst malformations or cortical infarcts each account for 15% of cases. Progressive refinements in brain imaging are proving increasingly helpful in determining aetiology although in almost 40% of those with congenital hemiplegia the aetiology remains unknown.

Gait analysis contributes invaluablely to the planning and monitoring of surgery. Many abnormal movement patterns may be encountered. The range of abnormalities and, consequently, the numerous surgical options to be considered may appear daunting to those less familiar with such a detailed analysis of gait. Yet, this is precisely the point; abnormalities of gait in hemiplegia are complex and even experienced clinicians cannot fully interpret gait from simple observation. Without formal gait analysis, inappropriate surgical options may be chosen resulting in deleterious, and occasionally disastrous, functional outcomes.

The mistaken view that a hemiplegia represents a straightforward motor disorder is not uncommon. A national hemiplegia support group has evolved rapidly because many parents struggle to understand their children's difficulties, having been reassured that the child merely had a simple, limited motor impairment. After establishing that the motor disability in congenital hemiplegia is often far from straightforward, the remainder of this book considers the additional problems that those with hemiplegia may encounter.

Around 20% of children with congenital hemiplegia have epilepsy which is intractable in about 25% of cases. Although epilepsy surgery may not be feasible, this option should be considered in any child with intractable seizures as surgical resection, including hemispherectomy, can be remarkably effective. The psychosocial impact of congenital hemiplegia is also reviewed. Psychological problems are managed using standard child mental health approaches, although the attitude of the child and family towards the hemiplegia, and the presence of intractable epilepsy, influence treatment. Children with hemiplegia may experience learning difficulties, particularly with respect to language and visuospatial skills. Left hemisphere lesions are more likely to result in educational difficulties, but the most powerful determining factors are the presence of epilepsy and overall cognitive ability.

Amongst the many thorough and thought-ful contributions, Scrutton's chapter on physical treatment stands out for its sensitive, patient orientated approach. Scrutton cautions that treatment, no matter how well intentioned, is unlikely to be successful if it is not considered to be entirely appropriate by the patient. This book increases the likelihood of appropriate, well informed and successful management being offered to those with congenital hemiplegia.

J Gibbs

PostScript

CORRECTION

www.archdischild.com