LETTERS

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

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. 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 intercostal drain for 2 days before resolution. Six months later, while again break dancing, he developed another pneumothorax, this time on the left side. Again he ignored it for a few days before consulting his GP. On this occasion, it was treated conservatively and resolved after 2 weeks without a drain, at which stage he was referred to our centre.

Examination and lung function were normal and a CT chest scan revealed tiny subpleural bullae at the apex of the left lung. Myopathy associated with hypothyroidism classically presents with proximal weakness, fatigue, 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.

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.

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

Myopathy associated with hypothyroidism is a rare condition. We describe 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 intercostal drain for 2 days before resolution. Six months later, while again break dancing, he developed another pneumothorax, this time on the left side. Again he ignored it for a few days before consulting his GP. On this occasion, it was treated conservatively and resolved after 2 weeks without a drain, at which stage he was referred to our centre.

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.

References

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References

Figure 1 The pleasures and perils of breakdancing. Reproduced with kind permission from the Jhoon Rhee Institute of Tae Kwon Do, Woodbridge, VA, USA.
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 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.

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. 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 thoughtful 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.

The author of the book review on Core Paediatrics and Child Health published in January 2002 (Arch Dis Child 2002; 86: 609) was H Davies and not MDC Donaldson. We apologise for the error.