

PostScript

LETTERS

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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.^{1–4} 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.

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.

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

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.^{1–3}

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 haemotology 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 (Eltroxin) 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.^{3,4} 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.

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

BOOK REVIEWS

Child Mental Health in Primary Care

Q Spender, N Salt, J Dorkins, T Kendrick, P Hill. Radcliffe Medical Press, 2001, £24.95, pp 381. ISBN 1-85775-262-7

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 25% 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-existent 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 vitally important 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

Edited by B Neville, R Goodman. Cambridge: MacKeith Press, 2001, £40.00 (HB), pp217. ISBN 1 898 68319 0

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 invaluable 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 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 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.

J Gibbs

CORRECTION

The author of the book review on Core Paediatrics and Child Health published in January (*Arch Dis Child* 2002;86:69) was H Davies and not MDC Donaldson. We apologise for the error.