Munchausen syndrome involving pets by proxies

In a letter in 1998 we drew attention to the fact that there was no reference to Munchausen syndrome by proxy described in the veterinary literature. Recently Munro and Thrusfield from the Royal School of Veterinary Studies, University of Edinburgh have published a paper in the Journal of Small Animal Practice, documenting the first series of reports of suspected Munchausen syndrome by proxy involving pets as proxies. In the study, 1000 randomly selected veterinary surgeons received a questionnaire specifically asking for details of their perceptions and experience of non-accidental injury in animals. A total of 448 cases were described, six of which were described by the respondents as possible Munchausen syndrome by proxy. Three other cases were identified by the authors as possible Munchausen syndrome by proxy. The nine cases are all described and show similarity to child proxy incidents. Common features include frequent requests for clinical review (up to four times in one day in one case), and frequent change of veterinarian (“veterinarian shopping”). In some cases the mode of clinical presentation was similar to that seen in paediatric practice, for example, presentation with haematuria or uncontrolled fitting. In one case a dog owner was insistant that a neighbour had poisoned his dog, but he was later convicted for the attempted poisoning of his child; in court it was revealed that he had previously attempted to poison two other pets treated by other veterinarians. In another case a cat owner gave an incoherent history with regard to the cause of injuries, and postoperative trauma occurred to the intramedullary pin. Repeated problems arose until the cat was admitted. The authors conclude that their findings should not only inform the small animal practitioner about a curious syndrome but also form the basis of broader debate in comparison between the experience of the veterinary and medical professions. Communication between child protection agencies, veterinary surgeons, and the RSPCA is beginning to occur in different parts of the country. Such liaison should be welcomed by paediatricians.

H S Tucker
Paediatric Specialist Registrar
Royal United Hospital, Bath, UK

F Finlay
Consultant Community Paediatrician, Child Health Department, Bath NHS House, Newbridge Hill, Bath BA1 3GE, UK

S Guillon
Veterinary Surgeon, 12 Ruby Place, Bath BA2 4EH, UK

LETTERS

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The prevalence of rickets among non-Caucasian children

We welcome the timely review by Shaw and Paton on the continuing problem of vitamin D deficiency among South East Asians living in the UK. Since our report in 1999, we have continued to see 8–10 non-white children with florid vitamin D deficiency per year, at our inner city general paediatric unit. A recent national survey showed that 20–34% of South East Asian children had biochemical evidence of vitamin D deficiency. However, there is no information on the prevalence of clinical rickets among non-Caucasian children in the UK.

We opportunistically studied 6–36 month old children from ethnic minority backgrounds who were brought to a child health clinic in Central Manchester between 30 May 2001 and 12 July 200 for immunisations, weight checks, hearing tests, and developmental assessments. A structured questionnaire was used to determine if the children were receiving vitamin D supplements and whether they had been prescribed by health professionals or bought “over the counter” by the parents. Arms and legs of children were examined for deformities and swelling of the metaphyses due to rickets. Children with clinical stigmata of rickets had an x-ray of their left wrist and estimation of serum calcium, phosphorus, alkaline phosphatase (ALP), parathyroid hormone (PTH), 25-hydroxyvitamin D (25(OH)D), and 1,25-dihydroxyvitamin D (1,25(OH)2D)3. Ethnicity was self determined by parents as East Asian (Pakistani, Bangladeshi, or Indian), African, Afro-Caribbean, and Middle Eastern origin. The study was approved by the Central Manchester Research Ethics Committee.

A total of 124 children (mean age 15.4 (8.2) months) were studied. Seventy seven per cent of children were of South East Asian origin and almost 50% were of Pakistani origin. Thirty (24%) children were receiving vitamin supplements; in 13 (43%) multivitamin preparations had been bought “over the counter” by the parents. Three children had clinical stigmata of rickets. Table 1 shows biochemical results. Two (1.6%) of these had radiological features of moderately severe rickets (fig 1) and the third had metaphyseal sclerosis, indicating healed rickets. One child was noted to be pale; his haemoglobin was 62 g/l (normal >110 g/l).

The Department of Health’s Committee on Medical Aspects of Food Policy (COMA) recommends vitamin D supplements for all children up to 3 years, and up to 5 years in those at high risk of developing vitamin D deficiency. It was therefore disappointing that less that a quarter of the subjects studied were receiving vitamin D supplements. Two children (cases 1 and 2) were found to have clinical and radiological evidence of active rickets. As shown in table 1, they also had biochemical features of rickets with elevated serum ALP activity for age, low serum 25(OH)D activity (a measure of an individual’s vitamin D status), and secondary hyperparathyroidism. All three had been breast fed for periods ranging between four and nine months after birth and none had been prescribed vitamin D supplements.

According to the 1991 census data there were approximately 4000, 6–12 month old children of ethnic minority background resident in the city of Manchester. We found that 1.6% of the children examined had rickets. If this figure were extrapolated to all 6–36

Table 1

<table>
<thead>
<tr>
<th>Case no.</th>
<th>Ethnic origin</th>
<th>Age (months)</th>
<th>Calcium (mmol/l) (2.15–2.6)</th>
<th>Phosphorus (mmol/l) (1.3–2.5)</th>
<th>Alkaline phosphatase (IU/l) (230–700)</th>
<th>Parathyroid hormone (pg/ml) (10–60)</th>
<th>25(OH)D (ng/ml) (20–50)</th>
<th>1,25(OH)2D (ng/ml) (20–50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pakistani</td>
<td>15</td>
<td>2.3</td>
<td>1.5</td>
<td>1859</td>
<td>192</td>
<td>10</td>
<td>103</td>
</tr>
<tr>
<td>2</td>
<td>Pakistani</td>
<td>8</td>
<td>2.4</td>
<td>1.4</td>
<td>1377</td>
<td>288</td>
<td>16</td>
<td>Insufficient</td>
</tr>
<tr>
<td>3</td>
<td>Pakistani</td>
<td>9</td>
<td>2.5</td>
<td>1.6</td>
<td>697</td>
<td>48</td>
<td>13</td>
<td>145</td>
</tr>
</tbody>
</table>

The normal ranges for biochemical variables are shown in parentheses.

1 Cases 1 and 2 had radiological features of rickets; a radiograph of case 1 is shown in fig 1.
2 Serum 25(OH)D levels <5 ng/ml are found in severe rickets, whereas levels <12 ng/ml are considered to be deficient.
3 Parents of this child has started him on “over the counter” purchased multivitamin preparation between being seen in the child health clinic and venepuncture, 10 days later.

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month old non-Caucasian children living in the Manchester area, we estimate that there would be approximately 60 children with rickets at the time of this study. Rickets is not a historical disease, as it seems to be perceived by many health professionals. However, it is an entirely preventable by use of vitamin D supplements as recommended by the COMA. We wholeheartedly agree with Shaw and Pal that a nationwide campaign, similar to the “Stop Rickets” campaign in the 1980s is needed to tackle this problem.

S Ashraf, M Z Mughal
Department of Paediatric Medicine, Saint Mary’s Hospital for Women & Children, Hatfield Road, Manchester M13 OJH, UK; zulf.mughal@man.ac.uk

REFERENCES
1 Shaw NJ, Pal BR. Vitamin D deficiency in UK Asian families: activating a new concern. Arch Dis Child 2002;86:147-9

Paediatricians’ misconceptions on childhood immunisations

Suboptimal immunisation practices of health care providers, mainly overly cautious interpretation of vaccine contraindications, result in missed opportunities for immunisation. In an attempt to identify deficiencies and misconceptions in the knowledge on childhood immunisations of community and hospital based paediatricians, with the purpose to plan appropriate teaching sessions, a quiz was developed from the common questions that I, as District Immunisation Coordinator, was asked. It was presented as short case studies, each having a number of answers to be marked as true or false, and validated by reference to Immunisations against infectious disease and current UK immunisation guidelines. The quiz was handed out before the training sessions on childhood immunisations in two districts and in the regional training session for “core” specialist registrars in paediatrics (first and second year).

Twenty four of 35 (69%) participants were junior doctors and 11 (31%) career paediatricians (staff grade, associate specialists, and consultants). Fifteen (43%) had more than four years experience in paediatrics. The sample of paediatricians was representative of the team of career and training paediatricians in district hospital and community paediatric departments. The percentage of correct answers per participant varied between 36% and 92% (mean 70.6%). The results showed that paediatricians, both career and in training, had a number of misconceptions about contraindications of childhood immunisations. The most problematic area was the advice given after local and generalised reaction following DTP/Hib combined in one injection. In addition there was marked overestimation of a mild to moderately severe local reaction as severe, regarded as contraindication to immunise. Those with less experience in paediatrics did not have less misconceptions, suggesting that all paediatricians require in depth discussion and regular update of the childhood immunisation schedule, contraindications to immunise, and how to manage missed immunisations.

E Stathopoulou
Consultant Community Paediatrician, Medway Maritime Hospital, Gillingham ME7 5NY, UK

REFERENCES

BOOK REVIEWS

Overgrowth Syndromes

Paediatricians are often more concerned about failure to grow rather than excessive growth. Bigger is not always better, however, and this relatively slim volume provides a wealth of information about almost all of the recognised overgrowth syndromes. Edited by some of the world’s experts on growth disorders, the book has gone through several editions. Although the issue of increased risk of neoplasia in overgrowth syndromes is raise, for example, there is no general guidance on screening affected children for tumours in childhood.

Despite these criticisms, I am sure that all paediatricians would enjoy delving into this book as they could not fail to find something of interest within its pages. From the point of view of the clinical geneticist or growth specialist the book provides a comprehensive review of overgrowth syndromes and will be a useful resource.

J Clayton-Smith
Handbook of Paediatric Intensive Care

George Bernard Shaw said “we have not lost faith, but we have transferred it from God to the medical profession.” Paediatric intensive care was born from the increasing technology and sophistication expected from medicine and is still a new and evolving specialty. A very small number of children will have the
misfortune to need to be treated in a paediatric intensive care unit (PICU). It’s an expensive business and often a very emotional one; but very real paediatrics. There are few PICUs in the UK and only six centres that are fully recognised for formal PICU training. Trainees may feel that mercifully few of them will rotate through PICUs as part of their training and that perhaps a book like this might not be for them. If that describes you I would encourage you to think again. Most PICUs are staffed with juniors who are paediatricians in training. Even if they decide that other areas in paediatrics interest them more, I believe most find their time in PICU valuable, varied and exciting. You won’t forget it. You won’t regret it. This book might suit you and there are not that many like it in the bookshops.

Gale Pearson is undoubtedly well qualified to write this book as clinical director in one of the largest units in the UK. Some of his passion for the subject comes through the text even when discussing “developing a Bayesian approach to PICU”. In a slim textbook a great breadth of the subject is covered including respiratory physiology, audit, congenital heart disease, and nutrition for example. Despite the breadth this book appears to me to have some depth and may be less of a handbook and more of an introductory textbook to PICU. There are valuable management suggestions and algorithms but much of the book is carefully selected background to the problems encountered in clinical practice and requires time to read and take it in. From a personal point of view there were a few areas that perhaps needed more coverage. If the intention was a bias to include common causes of admission to PICU, I think bronchiolitis deserved more than the 10 lines it got but maybe that’s my bias.

The book ends with a concise but detailed chapter: “Issues surrounding death on the PICU”. Public expectation is very high. Despite the public’s faith we are not the deities they see on the television and certainly not as good looking (not in the units I’ve worked in). We do our best—sometimes we fail. Samuel Beckett said: “Ever tried. Ever failed. No matter. Try Again. Fail again. Fail better.”

R O’Donnell

Practical Endocrinology and Diabetes in Children

This concise textbook has proved extremely useful in general paediatric ward and clinic work. Problem based chapters give an overview of the relevant physiology and a practical guide to examination, investigation, and management of a broad range of childhood endocrine disorders. Each chapter includes an interesting reference to controversial points in each field, future developments and example case history problems. There is also guidance on when to involve a specialist centre.

The authors have achieved consistency in the depth and approach of all chapters. The layout is modern, clear, and well illustrated which makes the book extremely readable.

The more unusual clinical problems such as intersex are included with remarkable depth and clarity for such a short text. The chapters on the common problems have been well thought out to cover practical questions. For example, the guidance on management of diabetes includes problems of long haul travel, surgery, alcohol use, and contraception in addition to practical aspects of ketoacidosis and cerebral oedema treatment.

The management guidance points are not individually referenced for level of evidence but represent established current practice. General references and key papers are given at the end of each chapter. Appendices list UK patient support group contacts and several growth charts, although height velocity and decimal age charts are not included.

The book is aimed at paediatricians in training and general paediatricians. In my department the book has also been used by nursing staff and doctors training in adult endocrinology. The authors achieve the difficult task of providing a text that is a good preparation for examinations in addition to a practical day-to-day guide. I would recommend the book to all candidates.

D P Smith