PostScript

LETTERS

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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.[1] 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.[2] 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 insistent 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.

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1 **Finlay F**, Guiton S. Munchausen syndrome by proxy. Abuse perpetrated by men. *Arch Dis Child* 1998;**79**:466.
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The prevalence of rickets among non-Caucasian children

We welcome the timely review by Shaw and Pal[1] on the continuing problem of vitamin D deficiency among South East Asians living in the UK. Since our report in 1999,[2] we have continued to see 8–10 non-white toddlers with florid vitamin D deficiency rickets 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.[3] 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 (25OHD), and 1,25-dihydroxyvitamin D ($1,25(OH)_2D$). Ethnicity was self determined by parents as South 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.[4] 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 25OHD (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 appproximately 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 Ethnic origin, age, and biochemical results in three children with clinical stigmata of rickets

Case no.	Ethnic origin	Age (months)	Calcium (mmol/l) (2.15–2.6)	Phosphorous (mmol/l) (1.3–2.5)	Alkaline phosphatase (IU/l) (230–700)	Parathyroid hormone (pg/ml) (10–60)	25(OH)D (ng/ml) (5–30)*	1,25(OH)D (pg/ml) (20–50)
1	Pakistani	15	2.3	1.5	1859	192	10	103
2	Pakistani†	8	2.4	1.4	1377	288	16	Insufficient sample
3	Pakistani	9	2.5	1.6	697	48	13	145

The normal ranges for biochemical variables are shown in parentheses.
Cases 1 and 2 had radiological features of rickets; a radiograph of case 1 is shown in fig 1.
*Serum 25OHD levels <5 ng/ml are found in severe rickets, whereas levels <12 ng/l are considered to be deficient.
†Parents of this child has started him on an "over the counter" purchased multivitamin preparation between being seen in the child health clinic and venepuncture, 10 days later.

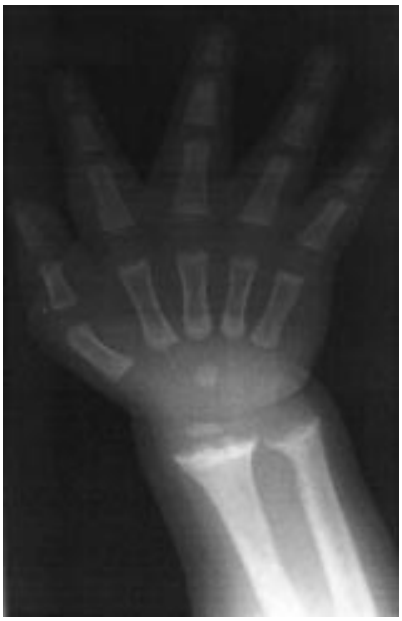

Figure 1 Radiograph of the wrist (case 1, table 1), showing wideing, cupping, and fraying of the distal radius and ulna.

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.[4] We wholeheartedly agree with Shaw and Pal[1] that a nationwide campaign, similar to the "Stop Rickets" campaign in the 1980s is needed to tackle this problem.

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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.[1] 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,[2] 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*[3] 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 70.66%). 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 longer 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.

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BOOK REVIEWS

Overgrowth Syndromes

Edited by M Cohen, G Neri, and R Weksberg. USA: Oxford University Press, 2001, $85.00, pp 224. ISBN 0195117468

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 focus is on multiple anomaly syndromes which have generalised or partial overgrowth as a feature. Although many of the conditions are rare some, such as Fragile X syndrome and neurofibromatosis, are common enough for this book to be of relevance to the generalist as well as the specialist. Along with details of conditions such as Sotos syndrome and Beckwith-Wiedemann syndrome there is information on many newly delineated overgrowth syndromes, reflecting the increased interest in overgrowth and the mechanisms giving rise to it over the past few years.

The format of this book and layout of the information within the chapters is traditional. Each chapter provides comprehensive coverage of a specific syndrome, including the clinical aspects, differential diagnoses and aetiology where known. The topics are well referenced and accompanied by many good quality, if rather dated, black and white illustrations. There are in addition chapters on chromosomal overgrowth syndromes, endocrine causes of overgrowth, and non-syndromic overgrowth, although the latter is rather brief and disappointing. An introductory chapter has fascinating historical facts about overgrowth and the way it features in ancient mythology. Some tales are hard to swallow, such as the birth of the mythical giant Gargantua through his mother's ear! A later discussion confirms that the "Elephant Man", Joseph Merrick had the condition of Proteus syndrome and not, as was originally thought, neurofibromatosis.

I found this book to be a very interesting read, and a superb source of references. The tables of clinical features in each chapter are also useful check lists when considering syndromic diagnoses. The molecular genetic information is reasonably up to date although it is unfortunate for the editors that one of the great mysteries of overgrowth, the cause of Sotos syndrome, was discovered just after this book was published. I am not so sure that this book would be the first choice of general paediatricians if their budget were limited, as even though the authors have provided clear explanations of many of the genetic mechanisms involved, some readers would find the more complicated genetic explanations containing a lot of molecular genetic jargon hard going. The book would also be of more relevance to those caring for children with overgrowth disorders on a day to day basis if there was more information on the general management of overgrowth syndromes. Although the issue of increased risk of neoplasia in overgrowth syndromes is raised, 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 good overall review of overgrowth syndromes and will be a useful resource.

J Clayton-Smith

Handbook of Paediatric Intensive Care

G Pearson. London: WB Saunders, 2002, pp 336. ISBN 0 7020 2346 9

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 speciality. 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

JE Raine, MDC Donaldson, JW Gregory, MO Savage. Oxford: Blackwell Science, 2001, pp 201. ISBN 0632051612

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