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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Childhood malaria in Britain

SIR,—Dr N Rutter's interesting paper (19 November, p 1335) is a reminder that ease of foreign travel has brought many tropical diseases into the paediatric outpatient department. Our experience over the past three years mirrors the national increase in malaria notification and illustrates some of the confusing clinical presentations of the disease.

During the period December 1974-December 1977 12 cases of malaria were diagnosed in this hospital in children aged between 7 months and 15 years. In eight cases the species involved was *Plasmodium falciparum*, in two *P vivax*, in one *P malariae*, and there was one mixed infection with *P falciparum* and *P malariae*. (In every case the identity of the parasite was confirmed by the Malaria Reference Laboratory.) The preponderance of falciparum malaria was to be expected, since the majority of the children were of West African parentage. The two children with vivax malaria both acquired their infection in Pakistan.

Five children developed symptoms within 72 h of arrival in the UK. The longest interval before symptoms became apparent was nine months (*P vivax*). One girl was diagnosed during investigation for haemoptysis and a second was referred by her general practitioner for a Paul Bunnell test and blood film for suspected glandular fever. A previously described patient[1] developed a swinging pyrexia following open heart surgery and a heavy *P falciparum* infection was found in a blood film taken on the 15th postoperative day. Two siblings with *P falciparum* malaria were referred because they had been falling asleep in school 18 weeks after arriving in the UK from Nigeria. The other patients presented with fever, malaria, or non-specific symptoms and some had splenomegaly. Nine of the children had received no prophylactic drugs and three had taken antimalarials intermittently, all stopping on arrival in the UK. All cases were successfully treated with oral chloroquine and primaquine where indicated.

It is clear from this small series that children with malaria may not present with classical symptoms and signs and unless the possibility of travel to endemic areas is constantly borne in mind the diagnosis may be missed.

M J ROBINSON
SUSANNAH EYKYN

Departments of Child Health
Microbiology,
St Thomas's Hospital,
London SE1

[1] Eykyn, S J, and Braimbridge, M V, *Lancet*, 1977, **2**, 411.

Management of children with nephrotic syndrome

SIR,—We were interested to read Dr J R T Gabriel's suggestion (19 November, p 1358) that treatment with diuretics pending spontaneous remission of nephrotic syndrome in children may be preferable to the prompt use of corticosteroids. It is accepted practice to withhold steroids for a few days after the onset of proteinuria in the hope of spontaneous remission, but the use of diuretics at this time is unwise because of the risk of inducing or exacerbating hypovolaemia. In our experience hypovolaemia is the commonest complication of steroid-sensitive nephrotic syndrome in childhood and is probably the most important cause of death in this condition, which generally carries a very good prognosis if properly treated. We recently reported that 14% of 72 episodes of acute renal failure in children were caused by hypovolaemia in nephrotic syndrome.[1]

The association of a rising haematocrit and oliguria facilitates the prompt recognition of hypovolaemia and indicates the need for infusion of plasma to restore plasma volume. Removal of oedema by diuretics, or very occasionally of ascitic fluid by paracentesis, early in a relapse should be undertaken only with close observation and with the concomitant use of plasma. In adults and older children in a stable relapse with no evidence of hypovolaemia oedema may sometimes be satisfactorily controlled with diuretic therapy and this may be preferable to the use of steroids if troublesome side effects are anticipated and further courses of cytotoxic agents are contraindicated. None the less, diuretics must be prescribed with great caution in the period immediately after relapse and in younger children.

S J CHAPMAN
R COUNAHAN
CYRIL CHANTLER

Evelina Children's Department,
Guy's Hospital Medical School,
London SE1

[1] Counahan, R, *et al*, *British Medical Journal*, 1977, **1**, 599.

SIR,—Following Dr J R T Gabriel's letter (19 November, p 1358) the following experience might be of interest.

In 1942 my son, then aged 7, developed the nephrotic syndrome. The only treatment at that time was restricted fluids and salt-free, high-protein diet, with urea as a diuretic. Because of wartime rationing the protein content of the diet was not as high as it should have been even though