LETTERS TO
THE EDITOR

Randomised trial of early tapping in neonatal post haemorrhagic ventricular dilatation: results at 30 months

EDITOR,—In reporting the results of follow up from questionnaires to the clinicians involved in the care of children randomised after the official end of this multicentre trial, Johnson et al have highlighted an important issue. Major functional loss can be identified at the age of 30 months by questionnaire, particularly when there is an unbiased comparison group. The presence or otherwise of children allocated to the control group who had ended; and then, at a later stage. It is not surprising that there are large differences between the proportions of children reported as being ‘normal’ and those having neuromotor impairment without functional loss, in children randomised before 31 January 1987 compared with those randomised after this date.

There may also be difficulties in categorising children as multiply or singly impaired without more formal testing. Silence or poor expression of concern at this age is associated with shyness – particularly in the unfamiliar context of a short clinic visit.

However, for secondary questions concerned with early detection, auditory sound findings and neurodevelopment at 30 months, the nature of the impairment matters. As always, the method to be used depends on what question is being asked. In the case of Johnson et al, refining the questionnaire will succeed in identifying all the impairments which are unaccompanied by functional loss at 2 years, unless the respondents are prepared to undertake a more detailed and structured assessment. By 4 years, it may well be possible to devise questionnaires which focus on these problems. I would strongly support their initiatives to evaluate alternative strategies for measuring health status in children.

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Dr Elbourne et al comment:
EDITOR,—All methods of ascertainment have advantages which need to be set against their potential problems for addressing particular questions. The advantages of a questionnaire to paediatricians asking them to provide information recorded previously in clinic records were largely pragmatic: it was cheap (trial funding had ended); did not require any special investigations; nor, in the context of a randomised controlled trial, was it likely to lead to a biased comparison between the treatment groups. However, as we and Dr Mutch point out, the method is probably not sensitive enough to detect impairments without functional loss in 2 year old children.

One way in which the sensitivity of this approach might be improved is by prospective completion of the questionnaire by the paediatrician at the time of a routine hospital check up. This may prompt a more detailed and structured assessment. Additional questions, which cannot normally be answered retrospectively from the questionnaire alone, can also be included. For instance, in the questionnaire used in the follow up of babies entered into a multicentre trial of the use of acetazolamide and frusemide in post-haemorrhagic ventricular dilatation questions about limb and axial tone and reflex changes. This is completed by the paediatrician at the time of an outpatient clinic visit.

By the time this trial was planned, the method for assessing groups of children will depend on the questions being addressed. In order to assess disability at particular ages, simple questionnaires may not only be sufficiently robust, but may be the only feasible in context of follow up for large groups of geographically scattered children. The resulting increase in statistical power may be more than offset the gains in accuracy which are made by using a more 'sensitive' test. It is in these sorts of issues that we are exploring in our research assessing the advantages and disadvantages of questionnaires completed by paediatricians in clinics, health visitors, GP’s and parents (and teachers for school age children).

Pro- or antioxidant activity of vitamin C in preterm infants

EDITOR,—It is of great interest that we read the paper by Silvers et al 1 describing plasma ascorbic acid concentrations and plasma antioxidant activity in premature infants at birth, and potential implications for reactive oxygen species induced injury. The antioxidant activity of plasma was tested by measuring plasma lipid peroxidation in rat brain homogenate, expressed as Dmax (plasma volume in µl required for maximum inhibition of auto-oxidation). In this in vitro system, as mentioned by the authors, 1 it is possible to extrapolate the results to the in vivo state. 2 We are therefore not surprised that plasma with low concentrations of caeruloplasmin (which has ferroxidase activity) and high concentrations of ascorbic acid (which can reduce free iron and initiate the formation of hydroxyl radicals through Fenton chemistry) has a low Dmax.

Although ascorbic acid can act as a pro-oxidant in the presence of free transition metal ions, it is a powerful antioxidant under other oxidative stress conditions. 3 Ascorbic acid scavenges directly a variety of reactive oxygen species, including superoxide and hydroxyl radicals, suppresses the inactivation of antioxidants by enzymes generated by the myeloperoxidase-halide system, neutralises oxidants released from stimulated neutrophils in a dose dependent manner, and can regenerate membrane bound vitamin E. 4 Ascorbic acid also has important metabolic roles — for example, in the biosynthesis of collagen, carnitine, and catecholamines.

The question, therefore, is whether in vitro observations such as the ones made by Silvers and colleagues 1 are relevant to the in vivo situation. The detection of non-transferrin bound iron in plasma of preterm and term infants 4 seems to support the authors’ concerns regarding a potential pro-oxidant effect of high plasma ascorbic acid levels in vivo. However, the various antioxidant and metabolic properties of ascorbic acid also have to be considered, and the integrated effect of high plasma ascorbic acid concentrations on the health status of premature infants is unknown. Therefore, we caution readers not to conclude that ascorbic acid is harmful to premature infants and that ascorbic acid intake needs to be restricted in these infants. Only carefully designed and designed adequately powered studies of vitamin C depletion or supplementation will be able to answer these important questions.

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Dr Powers et al comment:
There is no doubt that ascorbic acid has several important biochemical functions in the body, including under most physiological conditions, that of antioxidant. Under the particular conditions associated with premature birth, however, which include a low plasma concentration of plasma transferrin and caeruloplasmin, and possibly the presence of non-transferring bound iron, ascorbic acid present at high concentration would be expected to act as a pro-oxidant. Our published data suggest that this is indeed the case and show that high plasma vitamin C concentration at birth is associated with poor outcome. As further support for this argument we have recently demonstrated that at ratios of vitamin C:caeruloplasmin which we observe in premature babies at birth, vitamin C strongly inhibits the ferroxidase activity of caeruloplasmin. 1

We have not suggested that vitamin C is harmful to premature babies, but it is difficult to ignore the fact that high plasma vitamin C concentrations in infant formula are higher than those measured in human milk, and that formulas for premature babies are even more concentrated. The published hypothesis is based on the argument that premature babies need high intakes of vitamin C to catabolise tyrosine completely, but our stable isotope studies of tyrosine metabolism in preterm infants show that this is not the case. 2 Where there is no good evidence that high vitamin C intakes are beneficial, there are indications that they may be harmful. We would therefore advocate a thorough re-evaluation of current recommendations for vitamin C intakes of preterm infants rather than a reassurance that current intakes are appropriate.
