Hypothyroidism

There is general agreement that all patients with symptomatic hypothyroidism should receive replacement treatment.

MANAGEMENT

Thyroxine should be used in the routine management of hypothyroidism. The initial dose should not exceed 0.05 mg daily in patients over 40; an initial dose of 0.1 mg daily may be used in younger patients. The dose should be increased by increments until the patient is clinically and biochemically euthyroid. The optimum dose varies between 0.1 and 0.2 mg daily and higher doses are very rarely required. There is no need for triiodothyronine or tablets combining thyroxine and triiodothyronine in routine management, since these confer no additional symptomatic benefit, side effects are more common, and serum triiodothyronine levels are normal on thyroxine as there is a substantial extrathyroidal conversion of thyroxine to triiodothyronine. A raised serum thyroxine concentration is not, therefore, an essential prerequisite for adequate replacement treatment as has been claimed. There is only one particular indication for the long-term maintenance of a patient on triiodothyronine in preference to thyroxine: in patients who have had total thyroid ablation for thyroid carcinoma treatment should be stopped at regular intervals so that scanning procedures can be carried out. The replacement treatment can be

discontinued for a considerably shorter time if triiodothyronine is used. It is important to ensure that adequate hormone is given to suppress thyroid-stimulating hormone secretion in these patients since this is a major part of their management.

Replacement treatment with thyroxine must be introduced cautiously in patients with ischaemic heart disease, in whom it may not be possible to give full replacement doses. The addition of a beta-adrenergic blocker such as propranolol, which can be increased incrementally with the thyroxine, may allow patients with angina pectoris to tolerate a larger dose of thyroxine than would otherwise be possible.

There is no general agreement on the best treatment for hypothyroid (myxoedema) coma. It is common practice to give thyroxine in doses of 0.05 mg daily by mouth combined with triiodothyronine 20-40 µg daily by intramuscular injection together with hydrocortisone hemisuccinate 100 mg twice daily. Supportive treatment with fluids, assisted respiration, and treatment for cardiac failure or arrhythmias should be provided. The body temperature should be slowly raised to normal. It must be remembered that over-enthusiastic therapeutic activity can be as dangerous as inactivity in patients with coma.

The monthly *MIMS* index of proprietary preparations available in Britain includes the following trade names for the main drugs mentioned in this article (other than brand groups such as corticosteroids). Carbimazole: Neo-mercazole; potassium perchlorate: Peroidin; thyroxine: Eltroxin.

Problems of Childhood

Consultation, diagnosis, and management

ROY MEADOW

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The articles on problems of childhood which will be published during the next few months deal with common problems and worries that confront families and the doctors who help them. The articles have a strong emphasis on important aspects of management for the doctor responsible for primary care. Throughout the articles it is implicit that the doctor dealing with the case will be following the rules of a paediatric consultation. There are certain rules to be obeyed and guidelines to be followed in dealing with children. The rules will be adapted according to one's own personality, experience, and philosophy as a doctor, and also according to the situation, the child, and the family. Moreover, like all the best rules, the rules applicable to the paediatric consultation will need to be broken occasionally.

Consultation

If the child is very ill he is likely to be in bed at home with a parent nearby, but most children will be seen in a surgery

or a clinic. In that setting, while the infant can easily be at ease and happy in his mother's arms, to make the toddler or school child at ease requires tact, care, and planning.

Tiny chairs may be comfortable, but the doctor is much more likely to communicate well with the child if he is on the same level rather than towering over the child. Communication is also easier if the chairs are at right angles to the desk, and the child within touching distance: this avoids any semblance of the headmaster/pupil relationship, with the master on a big chair confronting across a desk a pupil in a smaller chair. A few models and blocks (2.5 cm coloured wooden cubes are best) on the desk give children of most ages something to watch or play with. A more generous selection of toys in the corner of the room will occupy accompanying brothers or sisters.

We all like to be called by our names and children are no exception. It makes them feel more secure to be greeted with "Hello Kevin" than "Hello little chap." (I sometimes wish that the thousands of elderly patients who get addressed as "Gran" and the children who are labelled "Little chap" or "Titch" returned the compliment by calling their doctor "Doc" or "Dad.")

The main practical problem of the paediatric consultation is the time it may take. Unless adequate time can be spent on children with recurrent and chronic disorders there is little chance of effective help. It is surely better to spend a lot of time trying to get to the bottom of a problem and to help with it than to spend the same amount of time over a succession of repeated brief visits and get nowhere.

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For many chronic and recurrent problems parent and child will need to be interviewed separately at some stage and a request such as, "Please will you wait outside while I talk with your Mummy and then I shall ask her to wait outside while I talk with you" should be made. When parent and child are together it is important to make clear to whom one is addressing a question, and yet at the same time to give both parties a chance to modify the other's answer. The questions asked of the child must be easy to answer: "How bad is the headache?" may be met with silence, whereas a response will be got from "Is it a big, middle-sized, or little headache? Does it stop you from going to sleep at night?"

Examination

A running commentary by the doctor is helpful for children of all ages. For the mother of the neonate it is as good to hear "The hips are normal" as it is for the young child to learn "Your heart is strong" or the older child "Your skin is nice and healthy." Children like gentleness, kindness, and politeness, and although "Please may I feel your tummy?" is a polite and proper question, for the younger child who might object it is probably best said in a confident but kind voice that makes it clear that the doctor *is* going to feel the child's tummy.

Instruments need to be explained, and because of this many children will be least worried if they are kept out of sight unless actually needed. Some apprehensive children with previous unpleasant medical experiences may need prior reassurance that there will be "no pricks or needles."

The disadvantage of an unpleasant or painful procedure has to be weighed against the value of the information gained from it. There is no point in making a child gag in order to get a better view of the tonsils unless it is essential (particularly as a reasonable view will usually be obtained by asking the child to put his tongue out).

Diagnosis

Doctors like to have a crisp diagnosis, which, they hope, might have a single cause, perhaps a single treatment, and then cure. Children need a comprehensive diagnosis. If it is a common acute infection, one needs to ask why this particular child got it. If it is a mild illness one must ask why these parents have singled out this illness as a cause for consultation. Children with recurrent and chronic problems can rarely be slotted into a simple diagnostic box: they will have associated and secondary problems—the schoolgirl with recurrent abdominal pain may have missed so much school that she is having problems with lessons, which itself predisposes her to more stress symptoms.

It is always worth asking parents and older children what they think the cause of the problem may be. One must give them lots of time to answer and a similar length of thought to their answer before any dismissal of their suggestion, or bland reassurance.

Management

INFORMATION AND REASSURANCE

Both child and parent require information and reassurance at their own level. Most problems of childhood do not result from serious disease; for many problems no physical cause can be identified. This is difficult for the parent, who may equate this with the doctor failing to appreciate that there is a problem. "Her kidneys, bladder, and urine are healthy" is of small comfort to the mother of a 6-year-old girl who is friendless and smelly because she wets her pants at school. Parents want a positive explanation about the origin of a symptom and not just a statement about what the problem is *not* caused by.

Parents can accept the truthful uncertainty of many medical situations "We don't know what the cause is, but we do know exactly what to do to help." Doctors in these situations are themselves comforted by having a clear plan of action and something to do. Parents also need to be given something to do for their child. Reassurance means restoring confidence, and the doctor dealing with children hopes that each episode of illness and each contact with doctors will leave the parents more confident in themselves, rather than more dependent on doctors.

TREATMENT

The child who feels ill will want to rest; the child who feels well will not. There is rarely any point in advising a parent to keep a child in bed unless the child is so ill that he wants to stay in bed. Parents often need to be encouraged to get their child up out of bed. Similarly, children should not miss school or opt out of school activities unless it is absolutely necessary. Teachers are generally tolerant of children with coughs, colds, and minor ailments. They know better than most people that missing time from school may be the most troublesome complication of many recurrent illnesses of childhood.

When prescribing drugs for children, apart from checking that the drug and its dose are appropriate for the age of the child, other factors have to be considered. Injections, which all children hate, should be avoided unless an essential drug cannot be administered by another route (perhaps because of severe vomiting). Most children prefer medicines, but some prefer tablets. Ask the mother. Some drugs are less suitable for children than for adults—for instance, tetracyclines are best avoided under the age of 8 because they damage and discolour the teeth and long-term steroids may stunt the child's growth.

Parents tend to stop giving the drug as soon as the child's symptoms have subsided. Therefore, prolonged courses of drugs should only be prescribed when they are important, and time must be spent explaining to the parent why the drug is important in the hope of achieving maximum co-operation.

What is primostat and how is it manufactured? How effective is it in reducing the size of a benign prostatic enlargement? What is the optimum number of injections and should they be repeated? If so, after what interval? Are there any side effects such as reducing the size of the external genitalia?

Primostat is a depot progestogen available in Britain as Depostat (Schering). The preparation contains 200 mg gestronol hexanoate (the active ingredient) in clear non-aqueous oily solution put up in 2 ml ampoules for intramuscular injection. Suggested uses are for endometrical carcinoma and in some cases of benign prostatic enlargement. At present its use in the latter connection is only recommended where: "(a) the patient is an operation risk; (b) symptoms are mild; and (c) [perhaps topically] there is a waiting list for operation." Some small clinical trials (mainly abroad) indicate that the drug is no substitute for effective surgical treatment. Indeed, there may be some risk in its use without competent urological assessment and it has been stated to be contraindicated in prostatic cancer. In various studies the effect on the prostate has been gauged by the symptomatic and local clinical response, estimation of the residual urine and peak urinary flow, urethral profile measurements, hormone inhibitory capacity, and histological changes in the rat. None of these criteria are entirely satisfactory. Nevertheless, there is general agreement that the drug inhibits local testosterone production and reduces spermatogenesis while individual observations relate to occasional mammary hypertrophy and reduction in weight of the (baboon's) testes. Recommended administration is by weekly intramuscular injection of 200-400 mg Depostat for 12 weeks with the proviso that full benefit is unlikely to be established until three months have passed. A warning is appended that exacerbation of bronchial asthma, epilepsy, or migraine may sometimes occur.