

Pegvisomant also lowered IGF-I concentrations and ameliorated symptoms in acromegalic subjects resistant to treatment with octreotide. Whether this GHR antagonist or later generations of GH antagonists will be useful in children is a matter for study. One hopes that such agents will not be employed to alter the growth of normally tall children, but its

use in other overgrowth syndromes will be of interest to explore in controlled settings.

Allen W. Root, MD

Herman-Bonert VS, et al. Growth hormone receptor antagonist therapy in acromegalic patients resistant to somatostatin analogs. *J Clin Endocrinol Metab* 2000;85:2958-2961.

Normal Growth Velocity Before Diagnosis of Celiac Disease

Celiac disease has been shown to result in nutritional growth retardation even in asymptomatic patients. However, there are instances in which this disease does not alter normal physical growth.

To evaluate height velocity of patients with confirmed celiac disease before and after diagnosis, anthropometric measurements were taken in 23 patients aged 0.1 to 10.66 years of age. All patients studied during the first 6 months of life showed normal growth velocity, and 6 of 10 patients showed normal growth velocity during the second 6 months of life. Ten of 12 patients between 1 and 2 years of age showed normal growth velocity and 7 of 9 patients aged 2 to 10 years also showed normal height velocity. The authors concluded that celiac disease could be present in children who are growing at a normal rate and that appropriate height and growth should not be factors that exclude the possibility of celiac disease.

Lejarraga H, et al. *J Pediatr Gastroenterol Nutr* 2000;30:552-556.

Editor's comment: *This paper is interesting as patients with confirmed celiac disease were followed longitudinally with reliable anthropometric data. While most of us have stressed the pres-*

ence of short stature and delayed growth as 2 of the most important clinical manifestations of celiac disease, it is important to be aware of the existence of untreated patients who grow at normal rates. This paper clearly documents that this indeed occurs but is contrary to the usual clinical presentation. Normal growth found in patients with celiac disease requires an explanation. The length of the lesion in the small bowel could be a factor leading to normal or abnormal growth. In countries where the prevalence of celiac disease is high, clinicians should be alerted to the possibility of this disease in a normal, asymptomatic, short-statured child with a previous history of diarrhea or iron deficiency anemia.

Fima Lifshitz, MD

2nd Editor's comment: *Unfortunately, the authors made only a minimal statement regarding the weight-to-height relationship. Twelve of the 23 patients had normal height and height velocity at diagnosis. Of all the children, 6 also showed normal weight increments before diagnosis. We can only assume that the phenomenon described occurs in children of normal weight for height and in children of low weight for height.*

Robert M. Blizzard, MD

Nutritional Rickets in African-American Breast-Fed Infants

Kreiter and associates report the characteristics of infants and children diagnosed with nutritional rickets at 2 medical centers in North Carolina in the 1990s. Records of 30 children were reviewed; 57% of these presented in 1998 and 1999. All were black and all were breast-fed (average duration of breast-feeding, 12.5 months). Breast-feeding has increased significantly since 1988 (Figure) in North Carolina in both black and white women. Children older than 1 year had a history of poor intake of fortified cow's milk or other dairy products. The age of diagnosis ranged from 5 to 25 months, but one third presented at 12 months of age or younger. Sixty-three percent were diagnosed between April and October, some of the warmer spring/summer months in this southern area. As expected, presenting signs included skeletal abnormalities (n=16) such as bowing of the legs, flaring of the wrist, costochondral beading, fractures, failure to thrive (n=13), hypocalcemic tetany/seizures (n=2), and developmental delay (n=1). Length was <5th percentile in 17 of 26 of the infants (65%), and only 2 patients had a length >50th percentile. With the exception of 1 patient who had

recently begun vitamin D treatment, all patients had hypophosphatemia. Sixty percent had hypocalcemia, and 100% had elevations in alkaline phosphatase.

All of the children with rickets were breast-fed without vitamin D supplementation. A survey of 400 pediatricians in North Carolina revealed that 42% prescribed vitamin supplements for all breast-feeding infants, whereas 42% prescribed supplemental vitamins only for selected breast-feeding infants (ie, those with dark skin who are being exclusively breast-fed for more than 4 to 6 months or who are premature). The authors also note that the 1997 American Academy of Pediatric Policy Statement indicates that "vitamin D and iron need to be given before 6 months of age in selected groups of infants (vitamin D for infants whose mothers are vitamin D deficient or those infants not exposed to adequate sunlight)" but that no guidance is given as to how to test mothers for vitamin D deficiency.

Kreiter S, et al. *J Pediatr* 2000;137(2):153-157.