Table 2. Median age and standard error of attaining menarche and stage 2 or above of each secondary sexual characteristic in the study group assessed by probit analysis

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Kalutara Median Age (yrs)</th>
<th>Colombo Median Age (yrs)</th>
<th>Combined Median Age (yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast ≥ 2</td>
<td>9.1</td>
<td>9.1</td>
<td>9.1</td>
</tr>
<tr>
<td>Pubic hair ≥ 2</td>
<td>10.0</td>
<td>9.6</td>
<td>9.8</td>
</tr>
<tr>
<td>Axillary hair ≥ 2</td>
<td>10.1</td>
<td>10.0</td>
<td>10.1</td>
</tr>
<tr>
<td>Menarche</td>
<td>11.2</td>
<td>11.2</td>
<td>11.2</td>
</tr>
</tbody>
</table>

References

Possible familial gestational spontaneous ovarian hyperstimulation syndrome due to mutation of FSH receptors (FGSOHS)

To the Editors:

The ovarian hyperstimulation syndrome (OHSS) most often occurs as an iatrogenic complication following ovulation induction. Overproduction of endogenous human chorionic gonadotrophin (hCG) during pregnancy has been associated with spontaneous ovarian hyperstimulation syndrome [1]. Familial gestational spontaneous ovarian hyperstimulation syndrome (FGSOHS) due to mutation of FSH receptors has been described in a recent report, in which the familial pattern suggested a genetic cause. A heterozygous mutation in
FSH receptors was identified in affected family members. Few mutations in FSH receptors have been reported but only one resulting in a gain of function. This mutation broadens the specificity of receptors, so that it responds to another ligand hCG [1,2]. Mutant FSH receptors lead to hypersensitivity to hCG. The onset and evolution of the syndrome coincides with the usual gestational time course fluctuation in hCG levels [3].

The proband, a 26-year old woman, presented in her second pregnancy with clinical features suggestive of OHSS. The first pregnancy had also been affected by the same condition, and had been terminated. The second pregnancy was spontaneously conceived. The patient had increasing abdominal pain, nausea and vomiting associated with abdominal distention at a period of amenorrhea of 9 weeks. Ultrasound scanning showed a multieocular mass, measuring 10 cm × 11 cm in both ovaries. Serum hCG levels were within the normal range for the period of gestation. She was managed conservatively with continued surveillance for complications. Subsequently, she underwent elective caesarian section at 38 weeks and delivered a normal baby. Ovarian biopsy was performed at the time of delivery and histology was compatible with OHS and excluded malignancy. Pedigree analysis showed that her two elder sisters had also had clinical features suggestive of OHSS in their pregnancies with no history of ovulation induction.

Although the definitive diagnosis of FGSOHS should be made by analysis of FSH receptors, in the absence of facilities to analyse mutant FSH receptors, our diagnosis was based on clinical features and a highly suggestive family history. Little is known about the pathophysiology of the FGSOHS [4,5]. The syndrome has a range of severity from mild to severe forms with the massive bilateral ovarian enlargement leading to life threatening situations requiring termination of the on going pregnancy [4].

References


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To the Editors:

Screening newborns for congenital hypothyroidism

Congenital hypothyroidism (CH) is a common preventable cause of mental retardation with a world wide incidence varying from 1:3000 to 1:4500 live births [1]. It has been estimated that 50,000 newborns each year are at risk of CH in the southeast Asian region [2]. Although screening of newborn for CH has been a routine practice in developed countries for more than 40 years, developing countries have addressed this concern only in the past decade [3]. A study done in August 2005 at Teaching Hospital, Gampola and base hospitals Mawanella and Nikaweratiya showed a high incidence of CH [4]. This stressed the importance of implementing a national screening programme for CH in Sri Lanka. We conducted a pilot study conducted in the Teaching Hospital, Mahamodara to assess the feasibility of a regional screening programme for CH.

This study commenced on 3rd October 2006 after obtaining approval from the Ethical Review Committee of the Faculty of Medicine, University of Ruhuna. Informed written consent was obtained from mothers at the time of drawing blood just before leaving the hospital. The blood spots were collected from 7 hours to 10 days after the