and precise observations.

Lastly, systolic fluttering of the tricuspid valve occurring only during inspiration was reported in one patient with chronic cor pulmonale and tricuspid insufficiency. Feigenbaum also mentioned systolic fluttering of the tricuspid valve in a patient with a ruptured sinus of Valsalva aneurysm and sorta-right atrial shunt, though there was no mention about this finding in the cited reference.

It is hoped that this communication may provoke a more incisive approach to this problem and careful review of the previous important observations.

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To the Editor:

We did not imply in our article that the fluttering of the tricuspid valve occurred only in association with ventricular septal defects. We agree with Drs. Doi and Spodick that other conditions reported previously with tricuspid valve fluttering should have been discussed in our manuscript. None of our patients, however, had evidence of left ventricular to right atrial shunt, tricuspid insufficiency or ruptured sinus of Valsalva aneurysm into the right atrium.

The tricuspid valve flutter in the figure furnished by Drs. Doi and Spodick is similar to our patients and compatible with membranous ventricular septal defect.

Although Snider et al reported in their paper that systolic motion and fluttering occurred anterior to the tricuspid valve, it is our theory that these echoes originated from the tricuspid valve which was forming part of the ventricular septal aneurysm. We feel that the systolic fluttering anterior to the tricuspid valve was probably as a result of streaming effect of left-to-right shunt through the membranous ventricular septal defect impinging on the tricuspid leaflet.

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An Unexpected Complication of Cystic Fibrosis

To the Editor:

Recently, pediatricians have given increased attention to the recognition and diagnosis of child abuse and neglect. The following case report illustrates the need for careful examination of all of the factors involved.

CASE REPORT

On August 25, 1976, the patient, then pregnant with her third child, requested help from her pediatrician. She was afraid she would severely injure her two young sons: 24 months and 16 months old. The pediatrician referred the case to his local protective service agency and on October 5, 1978, a recommendation was made for short-term removal of the children from the home and long-term counseling for the mother. The case was then transferred to another social worker for ongoing service. Thereafter, the two children were voluntarily placed in a foster home, only to be retrieved by both parents several days later. Therapy began with both parents, but was eventually terminated by the father because of lack of cooperation.

The patient’s third child was born on January 20, 1977. She informed her pediatrician that a CPS social worker was involved with her family. In numerous home visits by the social worker, the baby was seen as having adequate care. However, the patient was concerned about her baby’s small size. She attributed this to her and her husband’s small stature. During the course of visits to the baby’s physician, she was given various formulae to combat the baby’s slow weight gain. The mother became very concerned when the baby began wheezing and having a difficult time breathing. The child was then admitted to the county hospital where he was diagnosed as having bronchitis. At this time the parents separated, and the patient began to live with another man. Her mother-in-law became concerned about the youngest child’s care and took the baby to a local pediatrician. He referred the case again to the protective service agency.

As a result of this referral, the child was taken from the mother and placed in the care of the maternal grandmother, in spite of the ongoing local pediatrician’s objection. The child continued to lose weight and was then placed in the local general hospital where he stabilized for a few days and then again began to lose weight. On October 25, 1977, the child was admitted to Stanford University Medical Center. The mother remained in a local motel in order to maintain contact with her child.

At arrival at SUH, the infant was noted to be thin, tired, and cyanotic, less than a third percentile for height and weight and in obvious respiratory distress with superternal, substernal and intercostal retractions, grunting and nasal flaring, wet cough and audible wheezes. Notable on physical examination was a respiratory rate of approximately 50 to 60 and a heart rate of 150 with a reversed I to E ratio, rhonchi, inspiratory rales throughout and marked expiratory wheezes. A diagnosis of cystic fibrosis was confirmed by the sweat chloride level of 100. He was admitted to the intensive care unit.

After seven weeks, the infant was discharged to his mother’s home. On follow-up visits he has continued to gain weight and has notable clearing on chest x-ray examination and a clear chest on physical examination.

This is a case in which it was “easy” to diagnose this child as being neglected. The evidence was circumstantial; the mother herself had in the past sought help for fear she would abuse her two older sons. However, the assumption of abuse masked the correct diagnosis. It was only through careful observation of the mother and child’s interaction and a full pediatric evaluation that the correct diagnosis was made.

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