New cross sectional stature, weight, and head circumference references for Down’s syndrome in the UK and Republic of Ireland

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Aim: To present a growth reference for children with uncomplicated Down’s syndrome living in the UK and Republic of Ireland. Data are available for height and weight in the age range 0–18 years, including the first three months of life, and for head circumference in the first year.

Methods: The study sample was drawn from 16 discrete geographical areas and was representative of children age 15 years of age or less who are now living in the UK and Republic of Ireland. Multiple growth measurements for 1507 children were obtained retrospectively by case note search. Data from children with significant cardiac or other major pathology were excluded from analysis. Data from pre-term babies were excluded up to age 2 years. Centile curves were constructed from 5913 selected measurements from 1089 children and were derived using Cole’s LMS method.

Results: The resulting centiles differ substantially from those previously available in the UK, which were based on selective US data published in 1988.

Conclusions: We propose that these charts should now be adopted as the standard UK/Republic of Ireland reference.

SUBJECTS AND METHODS

Ethical approval was obtained from the South Thames Multi-centre Research Ethics Committee and from local research ethics committees.

Data collection

Community paediatricians in the UK and Republic of Ireland were approached through personal contact or by advertisement at national paediatric meetings, to see whether they had adequate special needs registers to identify all the children with Down’s syndrome in their geographical area. Sixteen such areas were identified: one each in the Republic of Ireland, Northern Ireland, and Scotland, and the remaining 13 in six of the eight geographically determined health regions in England.

All relevant medical records were searched by the local paediatrician or one of the authors (MS). Children were given an anonymous identification number. All records of height, weight, and head circumference were collected, together with the method and date of measurement, date of birth, sex, and gestation. Ethnicity was not consistently recorded in the source records, but assuming that in such cases the child was white, 94% of the sample was white. A record was also made of any coexisting illness (for example, heart disease, bowel disorder, or malignancy); the date and result of the most recent thyroid function test was also recorded. In addition data were incorporated from a cross sectional population based growth study in the Eastern Health Board area of the Republic of Ireland. To aid centile construction for the later teenage years, a further 27 young adults, aged 20–24, were recruited from a further education college, giving a total study population of 1507.

To avoid any child being over represented in the dataset, not more than two measures per year were included for children over 1 year and not more than four measures in the first year. A total of 8818 measurement episodes were entered into the dataset; 96% of children identified through the special conditions registers provided data.
Excluded children
Data for dead children still on the special needs register were excluded. Data from those with coexistent major pathology and/or preterm birth (less than 37 completed weeks gestation) were excluded as follows. Those with no abnormality or a small atrioventricular or ventricular septal defect, or a patent ductus arteriosus that had already closed or was asymptomatic were included in the study; those with a higher score or history of cardiac surgery were excluded. In addition children with other multiple or major pathology were excluded. Measurements for children born preterm were excluded for the first two years of life, but later measurements were included.

Measuring techniques
Reported measuring techniques were variable over time both within and between areas. In most areas staff had been trained, including paediatricians, clinic nurses, health visitors (more frequent in the under 5s), and school nurses (more common in the over 5s). Infants were weighed naked; older children were measured without footwear in underwear or light indoor clothing.

Equipment varied between and within areas. Standard clinic equipment included regularly calibrated scales and stadiometers. Community staff often used portable equipment that was less often calibrated.

The data collected between age 1 and 5 years contained measures of both supine length and height, because the age at which children with Down’s syndrome can stand unaided is extremely variable.

Statistical analysis
Data were cleaned in several stages. Bivariate plots of height, weight, and head circumference were used to identify gross disproportion. Data points so identified were scrutinised, going back to the source data if necessary, and transcription errors corrected. If a value was deemed highly unlikely (more than 5 SDs from the mean), but if there was no evidence of a transcription error, the point was deleted. In addition, runs of individual longitudinal data were scrutinised for evidence of unlikely measurements, such as apparent loss of height, and where possible, edited.

Centile curves were fitted to the data using Cole’s LMS method. Briefly, this assumes that the data can be transformed to normality by a suitable power transformation (L), and the distribution is then summarised by the median (M) and coefficient of variation (S). The values of L, M, and S are constrained to change smoothly with age, and the fitted values can be used to construct any required centile curves. Cole and colleagues give more details.

RESULTS
A total of 407 children were excluded because of cardiac disease or other major pathology. Of those remaining, 138 were preterm; 11 of these had no data after age 2, hence were excluded. After exclusions, the final sample consisted of 1089 children (597 boys and 492 girls). There were 5913 occasions with at least one valid measurement, providing 5681 weights, 4941 heights, and 2364 head circumferences. Table 1 gives the numbers of measurements by sex and year of age. A quarter of all measurements were in the first year of life, while there were relatively few points after 14 years of age.

Some subjects were measured on more than one occasion; one third of subjects provided just one measurement, representing 6% of all measurements. At the other extreme, 15 children each provided 20 or more measurements. The 868 subjects with between one and nine measurements provided half the total, the other half coming from the remaining 221 subjects with 10 or more measurements.

Centiles were fitted to the data using the LMS method. For height and head circumference the distribution was assumed normal; for weight there was appreciable skewness and the age varying power transformation was adjusted for it. Using these data, reference charts for girls and boys with Down’s syndrome in the UK and Republic of Ireland were constructed using the nine centile curve format proposed by Cole and used in the current UK 1990 growth reference (figs 1, 2, and 3).
DISCUSSION

We have produced the first growth charts relevant to children with Down’s syndrome in the UK and Republic of Ireland. While not based on a dedicated sample survey we believe the distribution of the contributing centres to be broadly representative. The advantages of using retrospective data collection rather than performing a prospective study are: firstly, the short time required to collect the data; secondly, the ease of recruiting a whole population rather than a smaller selected group of volunteers; and thirdly, the low cost.

The measuring techniques, equipment used, and personnel involved varied over time, both within centres and between centres. However, the variation we recorded reflects normal practice and for this reason, and because of the large sample size, we consider that the reference is wholly applicable for use in day to day practice. We note too that Cotterill and colleagues have shown that trained school nurses are as reliable as auxologists in assessing the height of schoolchildren.

In addition to the main child and teenage data a small number of measures were taken of young adults in order to facilitate construction of the curves in the late teenage years. Although the numbers were relatively small in later years the centile curves throughout childhood, and particularly in adolescence and early adulthood, look sensible, with the height and head circumference centiles flattening off as expected as adulthood approaches.

We believe that the curves reflect an accurate picture of the UK and Irish populations as they are and have been over the past 19 years. We do not propose that they are a standard to be achieved, particularly for weight in the older age groups where it is clear that a significant proportion of the population is obese. The tendency to overweight in late childhood and the teenage years is notable. Our data reveal that 30% of those aged 10 or more have a body mass index (BMI) greater than the 91st and 20% greater than the 98th centile for the general population. We have already mentioned that overweight is not inevitable in this population. For most, as in the general population, due attention to diet and exercise is effective in controlling overweight/obesity. We have shaded the area above the 75th weight centile in the 5–18 age range and referred the user to the UK 1990 BMI chart which we have reproduced on the front cover. We recommend that for the time being, as in the general population, those whose BMI lies above the 98th centile are significantly overweight (obese) and in need of further assessment and guidance, and those above the 91st centile are overweight and should be carefully monitored. It is likely that we will update this recommendation as we evaluate the usefulness of the charts in clinical practice.

Of those falling below the 2nd centile for height and/or weight, some will have major pathology. There is evidence that, as in the general population, those with major cardiac disease will be over represented at the lower end of the charts, as will those with other major pathology. We do not have sufficient data to construct charts for preterm babies and, as in the general population, advise that measurements for those born before 37 completed weeks gestation should not be plotted on the charts until the estimated due date is reached. Thereafter they should be charted relative to estimated due date for at least a year.

Preliminary data suggest that many babies with the syndrome do not regain birth weight until around 1 month. This is not reflected in the charts because of their cross sectional nature. This early failure to thrive is usually a result of feeding difficulties, many of which resolve after the first few weeks. However, the possibility of major gastrointestinal pathology (duodenal narrowing, gastro-oesophageal reflux) should always be borne in mind. We further advise that from 1 month, in the absence of major pathology, babies whose weight continues to fall through the centiles should have their dietary intake monitored, as ongoing feeding difficulties and failure to thrive are not uncommon in this population.

Individual children may show growth spurts and plateaus that are more prolonged than in the general population but which are not reflected in the reference charts. Similarly the charts suggest an absence of the pubertal growth spurt. Those with the syndrome do have an adolescent growth spurt, but it is usually less vigorous than in the general population and in some children may occur at an earlier age. When this happens it will impose a limiting effect on final height.

Comparison with the Castlemead/US charts, which have hitherto been the only Down’s specific charts available in the UK, reveals notable differences:

- The UK height centiles map fairly closely to the US charts between 3 and 12 years, but subsequently the US centiles drift below the UK charts so that by age 17 the US 50th centile for boys is below the UK 25th and the 25th around the 5th (fig 4). Note the discontinuity in the US centiles at age 3.

[Figures 2 and 3 are not transcribed as they are diagrams.]

Figure 2  Boys’ Down’s syndrome weight chart for the UK and Republic of Ireland.

Figure 3  Girls’ Down’s syndrome head circumference chart for the UK and Republic of Ireland.
The charts based on these data are printed for clinic (A4) and parental (A5, Personal Child Health Record format) use in the 9 centile format proposed by Cole. Following consultation with parents and doctors, the 0.4th, 50th, and 99.6th centiles from the 1990 UK growth reference are overprinted on the A4 charts and the PCHR inserts are available from Harlow Printing for steering through the final production of the charts. Copies of the A4 charts and the PCHR inserts are available from Harlow Printing, Maxwell Street, South Shields, Tyne and Wear NE33 4PU, UK.

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Conclusion
We present for the first time centile charts for weight, height, and head circumference appropriate for children with Down’s syndrome living now in the UK and Republic of Ireland. Those with the syndrome show different biologically determined patterns of growth from the general population; in addition, a range of both major and minor pathologies may further compromise growth. Growth surveillance throughout childhood will aid in the early identification of a range of pathologies and in the prevention of overweight and obesity, and can be best achieved by using syndrome specific charts. The charts presented here are more informative and accurate than the earlier US charts currently in use in the UK and Republic of Ireland. Differences throughout the age range have significant clinical implications. We therefore urge that use of the US charts should now be discontinued and recommend that the new charts are adopted as the standard reference for these two countries. The charts are published in A4 format for clinic use and in A5 format for use in the Parent Held Personal Child Health Record. They are therefore available for use in everyday clinical practice.

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H ow do you define nationality? For some I imagine that this is fairly straightforward. I find it a little more challenging. I know that I’m English, because I was born in England. In some parts of the world it is easiest to define oneself as English because being British is apparently synonymous—and somehow less clear. The phrase “Ah, English...Manchester United!” must be taught in schools around the world. I know that being English makes me British, but I also know that my country of origin—on official forms—is better described as UK, as this describes the United Kingdom of Great Britain and Northern Ireland. Besides, I don’t feel happy being happy to write British, I feel a certain pomposity about writing the “Great” in Great Britain: I can hear Cilla Black (an English 60s pop idol still going strong as a TV host) expressing the view that (referring to Margaret Thatcher) “Maggie put the Great back in Great Britain” and I shudder a little. Sometimes I look at my National Training Number and at my burgundy coloured passport, and at that point I know that I’m a European, but I have really no idea what that means.

My colleagues and friends here in no doubt that they are Australian. The majority of them are Queenslanders too, of which they are doubly and distinctly proud. Pride is a concept writ large in the Australian psyche, and sometimes overused to the point of ridiculousness. For example, a fast food chain does not simply sponsor a children’s soccer tournament: it “Proudly Sponsors” it, failing to see—or perhaps cynically exploiting—the strange juxtaposition between fast food and soccer tournament: it “Proudly Sponsors” it, failing to see—or perhaps overused to the point of ridiculousness. Just substitute it with “Black people are...” or “Jewish people are...” and you’ll begin to see the flaw. At a more trivial level, I often find myself saying “Cyclists are...” or “Paediatricians are...”. Of course, these statements are nowhere near as offensive as overtly racist comments, but at the same time they can easily include the same crass generalisations.

(in case you are interested, to Australians: “Poms are...infrequent bathers.” Apparantly we get by on only one bath a week, which seems like sheer indulgence to me. Pom, incidentally, is derived either from pompous, or from Prisoner of His (Her) Majesty; take your pick.)

To begin to turn this full circle: An Australian can be wholeheartedly proud to be an Australian, at the same time as disapproving of Pauline Hanson—right wing leader of the One Nation political party, mandatory sentencing, or the Australian Government’s handling of the MV Tampa stand off. This leads to an oddly circular situation, central to any nationalistic feeling, where the proud national makes a broad generalisation, whilst recognising that the generalisation is immediately and profoundly flawed.

Where does that leave me and my Englishness/Britishness/Europeanism? I don’t think I’m any the wiser, and I suppose I will continue to define myself depending on the circumstances, while harbouring a certain jealousy for the folk who see things more simply. However, I must leave this here, as there is an “a” in the month, and so it is time for my bath.

I D Wacogne

Dr Wacogne was on seconndment at the Royal Children’s Hospital, Brisbane for two years and is now completing his SpR training at the North Staffordshire Hospital, UK.

POSTCARD FROM DOWN UNDER

Is this a Pom I see before me?