

ing the prophylactic efficacy of ursodeoxycholic acid treatment would be cost effective. Moreover, as far as ethical issues are concerned, it should be considered that ursodeoxycholic acid therapy is virtually free of serious side effects.

Data reported by Lindblad et al. indicate that there is apparently a more delayed onset of liver disease in the Swedish compared with the Italian patients. Several factors may have played a role, including genetic and environmental differences between the two populations or differences in the criteria used for the diagnosis of liver disease,¹ which in turn may have conditioned different diagnostic sensitivities. In their letter, Lindblad and colleagues do not specify which criteria they adopted for diagnosis of liver disease. Regardless of the cause, while supporting the need for a prophylactic treatment, the Swedish data suggest that enrollment of patients with CF at a later age than the first year of life, as we have recently proposed,² would be more appropriate.

We agree that a survey on the prevalence of liver disease in patients with meconium ileus and its equivalent is a prerequisite for a study of ursodeoxycholic acid therapy as a preventive measure for development of liver disease. This had been planned when the study was designed, and a questionnaire is being mailed to CF centers in Europe specifically to address this issue.

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Short-term, high-dose corticosteroid therapy in childhood acute immune thrombocytopenic purpura

To the Editor:

We read with interest the article by Blanchette et al.¹ A therapeutic regimen that increases the platelet count above a safe level for preventing intracranial hemorrhage by use of orally administered corticosteroids in relatively low doses would be the preferred form of therapy, but we think that the continuation of this therapy for 3 weeks is disadvantageous because of the development of untoward effects and the prolongation of therapy. Side effects may occur with the continued daily use of corticosteroids, and the hy-

pothalamus-pituitary-adrenal system would be suppressed if steroids were administered for periods longer than 15 days.² Moreover, effective treatment without any side effects have been reported in studies in which methylprednisolone was used in very high doses orally for 1 week.³ We are still investigating the effect of orally administered methylprednisolone, 10 mg/kg per day, for 5 days in the treatment of acute immune thrombocytopenic purpura in children. The preliminary data for 10 patients revealed mild elevation of the blood glucose concentration in two patients on day 3 and in the occult blood in the stool in one patient on day 7, which were transient. The mean platelet count increased from $21 \times 10^9/L$, to $47 \times 10^9/L$ on the third day of therapy. The platelet count decreased below $20 \times 10^9/L$ in only one patient during follow-up.

We believe that short-term therapy with high doses of corticosteroids is as effective as long-term therapy and may decrease the side effects of steroid use. In addition, administration of intravenous immune globulin G, which is very expensive and also has adverse reactions, should be preserved for patients who are unresponsive to high doses of prednisolone or who have serious bleeding.

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Reply

The comments of Drs. Buchanan, Özsoylu (*J PEDIATR* 1994;125:503), and Yavûz and colleagues are important; they focus on the two most important issues concerning treatment of children with acute idiopathic thrombocytopenic purpura (ITP), namely whom to treat and what modality to select if a decision to treat is made.

Dr. Buchanan favors a "noninterventionist" approach with treatment of the child rather than the platelet count. He cites a very low incidence of intracranial hemorrhage (ICH), high cost of intravenous immune globulin therapy, and adverse effects of therapy as support for his opinion. Our approach is different. We believe that children with acute ITP and platelet counts $<20 \times 10^9/L$ are the group "at risk" for ICH, and that such children should immediately be offered the minimum therapy necessary to a rapid