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Correction

Glomerulonephritis: diagnosis and treatment

Several paediatric nephrologists have pointed out an error in this review article by P D Mason and C D Pusey (10 December, pp 1557-63). On p 1558 Mason and Pusey state that children with minimal change nephropathy should be treated with prednisolone 1 mg/kg/day (or 2 mg/kg on alternate days) for eight to 12 weeks or for one week after induction of remission. A recent consensus statement, however, recommends prednisolone 60 mg/m²/day (maximum 80 mg/day) until remission, followed by 40 mg/m²/day (maximum 60 mg/day) on alternate days for four weeks. The prednisolone is then stopped without the dose being tapered.[1] The first two relapses should be treated in a similar way. Children with frequent relapses should be given, in the first instance, maintenance treatment with prednisolone 0·1-0·5 mg/kg on alternate days for three to six months. The initial, high doses of prednisolone can be continued for four weeks; the advice of a paediatric nephrologist should be sought if remission has not occurred by then.

1 British Association for Paediatric Nephrology-Research Unit, Royal College of Physicians. Consensus statement on management and audit potential for steroid responsive nephrotic syndrome. *Arch Dis Child* 1994;**70**:151-7.

ANY QUESTIONS

What can be done to help a 20 year old man with excessively sweaty hands and feet?

Hyperhydrosis can be debilitating and preclude the sufferer from many jobs. The severity ranges from a persistent dampness of the hands and feet to a severe form, in which the hands continually drip. On the soles this can lead to secondary bacterial infection with pitted keratolysis and an offensive smell. Sweating can be induced by thermal stimuli or anxiety.

Treatment of hyperhydrosis can be difficult and consists of both medical and surgical intervention. In mild hyperhydrosis 20% aluminium chloride can be effective.[1] The best time to apply this is at night, when sweating is at its lowest, and this may result in relative dryness of the palms and soles during the day. The application of 20% aluminium chloride can irritate the skin, and many patients do not like it as it tends to make the skin sticky. Probably the most satisfactory method of controlling hyperhydrosis is by iontophoresis with glycopyrronium bromide.[2] This technique is usually provided by the physiotherapy department and involves immersing the palms and soles in a solution of glycopyrronium bromide made up in tap water, after which a low current is passed through the solution. The anticholinergic drug is taken up into the skin and blocks the autonomic nerve supply to the sweat glands. Iontophoresis needs to be performed regularly until control has been achieved, after which maintenance treatment every one to two months may be sufficient to maintain control. Minor systemic effects may be experienced, such as dry mouth and eye symptoms. Systemic atropine-like drugs have been used in the past, but in most cases the side effects are more troublesome than the hyperhydrosis.

In patients who are severely debilitated and who are not responding to medical treatment surgical treatment with sympathectomy can be effective in controlling hyperhydrosis.[3] Unfortunately, sweating tends to recur after some years, due to regeneration of sympathetic fibres or fibres that do not pass through the sympathetic ganglia.—A C CHU, *consultant dermatologist, London*

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