but found that the phenomenon was still present nine to 12 months after the end of treatment.

The optimal treatment regimen has yet to be established, but this may now be possible as synthetic growth hormone becomes more widely available.

We thank the locally organised clinical research committee of the North East Thames Regional Health Authority and Children Nationwide Medical Research Fund for financial support.

Diagnosis of rotavirus gastroenteritis by smell

J POULTON AND M J TARLOW
East Birmingham Hospital, Birmingham

SUMMARY Clinical features cannot differentiate rotavirus gastroenteritis from other types of diarrhoea. Sixty eight stool specimens were examined by nurses on an infant gastroenteritis ward. Of these, 69% were correctly classified by smell alone. The results are significant (p=0.009) and support the suggestion that rotavirus stools have a characteristic smell.

The appearance and smell of stools have always interested physicians,1 and the smell of the stool has provided an important clue in establishing the original link between enteropathogenic Escherichia coli and neonatal gastroenteritis.2 The present study was undertaken because it was noticed that the nurses on a paediatric infectious disease ward usually diagnosed rotavirus gastroenteritis correctly before the results of culture were available. They considered the appearance and smell of the stools to be of diagnostic value. Our aim was to test the hypotheses that rotavirus gastroenteritis could be diagnosed by either the smell of the stool alone, or a combination of smell and appearance.

Patients and methods

Overnight stools were collected from 23 babies with diarrhea, aged 0–18 months (mean 4.8 months), and coded by night staff. Table 1 shows the causes of the diarrhoea. The stools were randomised and examined by day staff at 9.00 am the next morning. Each stool was examined in two ways. The first way by smell alone, the specimen pot being wrapped in a paper towel, and the nurse keeping her eyes closed. She was asked to classify it as rotavirus or not rotavirus; ‘don’t know’ was not allowed. For the second examination the paper towel was removed and she was asked to inspect the stool and given the opportunity to change her opinion. Seven nurses made 68 examinations of 33 stool specimens over three months.

The ages of the children, the feeds given, and the ages of the stools were comparable.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No of babies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive for rotavirus</td>
<td>10</td>
</tr>
<tr>
<td>Rotavirus only</td>
<td>8</td>
</tr>
<tr>
<td>Rotavirus and adenovirus</td>
<td>1</td>
</tr>
<tr>
<td>Rotavirus and enteropathogenic E. coli</td>
<td>1</td>
</tr>
<tr>
<td>Not positive for rotavirus</td>
<td>13</td>
</tr>
<tr>
<td>Adenovirus</td>
<td>2</td>
</tr>
<tr>
<td>Campylobacter</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory infections</td>
<td>4</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>2</td>
</tr>
<tr>
<td>No organism isolated</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 1 Diagnoses in 23 babies studied
Table 2 Correlation of diagnosis by smell of stool and by culture

<table>
<thead>
<tr>
<th>Diagnosis from culture</th>
<th>Nurse's diagnosis by smell of stool</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No positive for rotavirus (%)</td>
<td>No negative for rotavirus (%)</td>
</tr>
<tr>
<td>Positive for rotavirus</td>
<td>10 (38)</td>
<td>16 (62)</td>
</tr>
<tr>
<td>Negative for rotavirus</td>
<td>5 (12)</td>
<td>37 (88)</td>
</tr>
<tr>
<td>Total</td>
<td>15 (22)</td>
<td>53 (78)</td>
</tr>
</tbody>
</table>

Results

Table 2 shows the results of examination of stools by smell alone. Sixty nine per cent of stools were classified correctly. The sensitivity was 38% (χ² using Fisher’s exact test; p=0-01). When the variation between nurses was taken into account the significance was unchanged (Cochrane’s test; p=0-008). The information about stool appearance did not materially affect the results.

Discussion

Experienced nurses classified most of the stools by smell alone; it seems likely, therefore, that stools infected by rotavirus have a distinctive smell. As stools infected with enteropathogenic E coli also have a characteristic smell, it may be that other organisms causing diarrhoea may also be identified by smell.

None of the clinical features of rotavirus diarrhoea distinguishes it clearly from diarrhoea caused by other organisms, though studies of inpatients have suggested that fever, frequent vomiting, isotonic dehydration, and lack of white cells in the stools are more commonly associated with diarrhoea caused by rotavirus. The smell of the stool could, therefore, be a useful aid in diagnosis.

Only 38% of the stools containing rotavirus were correctly identified, so the sensitivity of smell alone as a diagnostic test is low. These results might be improved if the nurses were told the results of culture at the time they made their diagnosis, and allowing them to change their minds in cases of uncertainty.

It is not clear what causes the distinctive smell; rotavirus damages the mucosa of the small intestine directly, not by producing a toxin. Its effect on stool composition, therefore, is probably indirect disruption of normal gut function, or a change in the normal gut flora.

Damage to the brush border reduces disaccharide concentration both in man and animals, and endopeptidases are probably also affected in this way. Disaccharides and peptides may, therefore, be present in the stools in increased concentrations. Derivatives, such as lactic acid, are volatile and pungent, and could affect the smell of the stools.

Any change in the composition of colonic fluid will unbalance the normal flora which carry out many metabolic processes. Such change could affect the relative concentrations of pungent products, including short chain fatty acids and indoles, thereby altering the smell.

Disturbances in the fatty acid and bile acid concentrations in stools have been shown in patients with chronic diarrhoea by chromatography, and this might also be a useful technique for diagnosing acute gastroenteritis in children.

We conclude that the smell of the stools of infants with acute gastroenteritis may help to diagnose rotavirus and possibly, other infections.

We thank Sisters Treadwell and Ostrowska and the nurses on ward 31 at East Birmingham Hospital without whom we could not have carried out this study.

References


Correspondence to Dr M J Tarlow, East Birmingham Hospital, Birmingham B9 5ST.

Received 16 February 1987
Diagnosis of rotavirus gastroenteritis by smell.

J Poulton and M J Tarlow

Arch Dis Child 1987 62: 851-852
doi: 10.1136/adc.62.8.851

Updated information and services can be found at:
http://adc.bmj.com/content/62/8/851

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/