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paid. The cost savings from non-transplanted
livers were equally impressive even at the dis-
counted price of £30,000 per transplant. Are we
to believe that these spare livers would not be
used for some equally deserving cases thus
resulting in no net saving to the health
service? As a paediatrician I remain uncon-
vinced by the arguments advanced that a
national screening programme at two weeks
after delivery will solve this clinical dilemma.

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1 Mowat AP, Davidson LL, Dick MC. Earlier iden-
tification of biliary atresia and hepatobiliary dis-
eresecreening in the third week of life.

Professor Mowat and Dr Dick comment:
We are please to have Professor Matthew's
support in trying to achieve surgical treatment
for all infants with biliary atresia by 60 days of
age. Because we share some of the concerns he
expresses, we do not advocate screening for
biliary atresia but selective screening or more
correctly case finding by detecting
conjugated hyperbilirubinaemia in jaundiced
infants as we will detect all forms of hepatobiliary
disease. Most will have other hepatobiliary
disorders for which early and specific treat-
ment is desirable. By screening at the same
time as the infant is being assessed by com-
monly held paediatric care professionals much of
the cost and logistic difficulties will be minimised.

King's Healthcare Trust is undoubtedly
in the real world. Next year the cost for a direct
bilirubin will increase to £4.00 including all
overheads. Since since our two years 25
infant aged 18 days with biliary atresia was
'looked over' by a member of our junior staff.
The total serum bilirubin concentration was
72 μmol/L. We cannot stress too strongly the
infant with biliary atresia in the first weeks of
life appears well. The only constant abnormal
clinical feature is jaundice which may be very
mild and urine which is persistently yellow
and new born. In the last two years 25
infants and children in UK died while on
waiting lists for liver transplantation. If any of
these were alive because a selective screening
made transplantation unecessary for one
child with biliary atresia, would any paediatrici-
an object?

Because the optimum time for screening is
controversial, community staff in our district
are testing for conjugated hyperbiliru-
biinaemia in jaundiced infants of different ethnic
backgrounds. This study funded by the
Children's Liver Disease Foundation will
clarify logistical difficulties and the prevalence
of benign jaundice in the third and fourth
week after birth.

Double blind placebo controlled trial of
pizotifen syrup in the treatment of
abdominal migraine

Dr Symon and Dr Russell comment:
Recurrent abdominal pain is a symptom and not
a diagnosis. We find no difficulty in accepting
that children with recurrent headaches may be
suffering from a wide variety of different diseases,
including migraine, tension headaches, and even
cerebral tumours. Similarly recurrent abdominal
pain may be the final symptom of a wide
variety of disease processes. In our practice
the commonest cause of recurrent abdominal
pain is constipation. The concept that all
recurrent abdominal pain is psychosomatic in
origin has been discredited by the absence of
any statistically significant differences
between those with recurrent abdominal pain and
pain free children with regard to various psychological variables thought to be
associated with psychogenicity.2

The children whom we treated in our trial
were not suffering from recurrent severe disabling
symptoms. Unlike

bellowchers their symptoms came in discrete
attacks with complete normality between
episodes. We accept that the term 'abdominal
migraine' is not universally accepted. The
arguments for this were fully rehearsed in a
recent clinical controversies article.2 Perhaps
there would be fewer objections if the syn-
onym had a different epithet such as
Buchanan's syndrome, as some people
wish to reserve the term migraine solely for
headaches on the basis of its presumed
eymological derivation from hemiargia.

We would not expect pizotifen to be of
benefit in all children with recurrent abdomi-
nal pain and logically we feel that it is unlikely
that pizotifen would be of value in recurrent
abdominal pain other than abdominal
migraine. We are not aware of any trials of
the use of pizotifen in recurrent abdominal pain
other than our own trial in abdominal
migraine.

To lump together all children with recur-
rent abdominal pain as having psychosomatic
pathology is to do grave disservice to those
patients who come to us seeking relief of
their symptoms.

Medicalisation of the normal
variant - treatment of the short,
sexually immature adolescent boy

EDITOR.—I enjoyed Christopher Kelner's
annotation but as a non-endocrinologist am
unhappy about his advice for delayed puberty
in the absence of disease that 'boys over 14 years of age ... who have impaired self image and social withdrawal not responding to reassurance' should be considered for treat-
ment. If they 'should not be denied when appropriate'.1

There are two issues. Firstly the wide
spread use of potent endocrine agents for a
condition which may not be associated with
hormonal imbalances. Can we really
establish that there will be no long term adverse effects
during the lifetime of the individuals concerned or, indeed, of their progeny? Patients
need to know whether they want to take the risks and doctors need to be accountable," states Brendon Nelson, the president of the
Australian Medical Association, in considering
the unexpected long term consequences of another endocrine intervention, Creutz-
feldt-Jakob Disease.2 The prospect of perma-
nent gross dwarfism probably, even in
retrospect, justified the, at the time
unpredictable and thus unquantifiable, long
term risk. Does the transient and common phe-
nomenon of delayed puberty? We must surely
include permanence as well as severity and
incidence in any therapeutic cost benefit
analysis.

Secondly, and more importantly, we need
to be careful, as paediatricians, not to narrow
the range of accepted normality and to
medicalise normal variation. A teenager with
delayed puberty may have impaired self image
and social withdrawal at the age of 15. Where
is the evidence that short term manipulation
of the situation with drugs is of long term
benefit? Can we really define all of the
future man, quite apart from its implications

1 McGrath PJ, Goodman JT, Firestone P, Shipman
R, Peters S. Recurrent abdominal pain: a psy-
chosomatic disorder? Arch Dis Child 1983; 58:
888-90.

2 Symon DNK. Is there a place for 'abdominal
migraine' as a separate clinical entity? C30; 12:
346-8.

3 Buchanan JA. The abdominal crises of migraine.
J Neurol Ment Dis 1921; 54: 406-12.
for those at the extremes of the normal range for fat/thin, short/tall, clever/stupid, clumsy/ agile, white/black individuals?

My own puberty was late. Not much fun at the time but the resultant temporary exclusion from full membership of the peer group has produced a useful long term lesson in coping with the natural ups and downs of life. Explanation, empathy, and reassurance are in my view better medicine in this area, as in many others, than use of medication.

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Dr Keinan comments:

I am grateful to Professor Boyd for his comments on my annotation. I hope that I emphasized sufficiently that explanation and reassurance may be all that is required. A decision has to be made on clinical grounds as to whether that is the case – a situation frequently faced by paediatric endocrinologists and many general paediatricians.

I also discussed the poor quality of some previous studies and the need for more scientific information before definitive recommendations can be given. In that regard, studies are in progress in a number of centres and a further contribution from this department is soon to be published in this journal. Selective and appropriate hormone treatment is not designed to ‘narrow the range of normalcy’ (nor will it do so) but to relieve distress. The extent to which it achieves this has also been assessed scientifically and such studies are also in progress in this department and elsewhere. Not all boys presenting with short stature and pubertal delay are ‘future Professor Boys’ and some are likely to be significantly socially and psychologically disadvantaged at a time which is critically important for determining future work or career prospects. Potential physical consequences of delayed puberty also require proper prospective evaluation.

I believe, with Professor Boyd, that ‘explanation, empathy, and reassurance’ are often enough. Where they are not, my view is that effective hormone treatments are now available and can reasonably be considered and prescribed on the basis of currently available scientific knowledge.


Minoxidil induced hair growth after leukaemia treatment?

EDITOR—Although hair loss is an invariable accompaniment of chemotherapy for acute lymphoblastic leukaemia (ALL), regrowth is usually prompt and complete. After unusually intensive and prolonged chemotherapy hair may not regrow properly. We report the successful treatment of one such case.

Case report

A 4 year old boy presented with common ALL. He was entered into the Medical Research Council (MRC) UKALL X trial, receiving 18 Gy as central nervous system prophylaxis.

After two years of treatment he was found to have central nervous system leukaemia and therefore was started on a relapse protocol (subsequently formulated as MRC UKALL R1). He tolerated this intensive regimen poorly and developed multidermatome shingles, so that after 16 weeks he was put on a maintenance regimen (vincristine, prednisolone, mercaptopurine, and methotrexate). He received a further 24 Gy of craniospinal irradiation.

After the later two year course of treatment the hair that regrew was only thin and wispy. It remained in this state for a period of 14 months. Minoxidil solution 2% was applied daily to the scalp. Over a period of nine months an almost normal head of hair was regained.

Abnormal hair growth was first noted as a side effect of the antihypertensive agent minoxidil. Topical minoxidil also stimulates hair growth and has been used to growth baldness.1 It has been tried, unsuccessfully, to modify acute hair loss during chemotherapy;2 we cannot find any examples of the use described here.

This patient’s hair did not improve for 14 months before the application of minoxidil, leading us to believe that minoxidil caused the hair regrowth. It would be of interest to hear of other experience in alleviating this distressing side effect.

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Colonic strictures in cystic fibrosis

EDITOR—We read with interest the letter by Green et al reporting two patients with cystic fibrosis who developed colonic strictures while receiving high strength pancreatic enzymes.1 The clinical presentation in both these cases was very similar to our original report in 19942 and to the cases of fibrotic strictures in cystic fibrosis which have been described subsequently.3 We disagree, however, with Green et al that bowel ultrasonography is unhelpful in the diagnosis of this condition, and indeed they provide no evidence to support this assertion. The typical findings on ultrasound in these strictures are of bowel wall thickening, with reduced peristalsis and free fluid associated with the lesions. Although the site and extent of the lesions can be most accurately defined by contrast studies, we would suggest that ultrasound is a more pleasant and less invasive initial procedure in the young child with abdominal pain.

Abdominal pain is a very common symptom in patients with cystic fibrosis, but because of the recent concern about fibrotic strictures, radiological investigations into the cause of such pain are now being performed early. Our practice is to perform a plain abdominal radiograph and ultrasound of the bowel. If both these investigations are abnormal, then there is little to be gained by proceeding to contrast studies.

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Dr Green and coauthors comment:

We agree that bowel ultrasonography has a role in the diagnosis of colonic strictures, however, we feel that it is an observer dependent investigation. While it is a valuable screening procedure in Dr Corry’s hands this may not be the case with less experienced interpretation. In the child with recurrent and troublesome abdominal pain it would be unfortunate to miss the occasional intussusception on the case. It is by not proceeding to contrast studies. We would therefore be reluctant to suggest relying entirely on a normal plain abdominal film and ultrasound as routine practice in every centre.

Management of anaphylactic reactions to food

EDITOR—Patel et al draw attention to the use of wrist badges for children with potentially life threatening anaphylactic reactions.1 As a community paediatrician who has been responsible for the support of over 20 children with this problem over the last two years I must strongly disagree with their view. Detailed discussion with the parents of children in our area shows that they are keen that their children should not be labelled, either by badges or ‘minders’ in school. We must remember that these children are normal, but with a risk of serious reactions to foods. Support to schools must emphasise prevention (that is, exclusion of allergens from the environment) and management of the (unlikely) reaction. Labelling children may in fact reduce the focus of removing the allergen from the environment and thereby increase the risk to the child. Many food allergens are not obvious (for example, nut oils in foods) and we must not rely on badges to protect these children. The labelling approach is dangerous and may lead to the segregation of these children from their peers. It may also lead to bullying of these children, and encourage other children to offer them the ‘forbidden’ food. I would urge all paediatricians involved in child care to reject this approach and concentrate on working with schools and parents to support these
Medicalisation of the normal variant--treatment of the short, sexually immature adolescent boy.
R D Boyd

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