birthweight; in 3 out of 4 babies in whom I attempted to pass the tube the tip lodged in the first part of the duodenum and would not negotiate the duodenal loop. It is possible that this difficulty could be overcome by using a tube with a shorter weight at the tip.

I have had no experience with NJ tube feeding in babies being mask ventilated, but Wells and Zachman¹ and Beddis and McKenzie² reported considerable difficulties and a high complication rate; this would seem to be a contraindication for transpyloric feeding.

References

- 1 Wells D H, Zachman R D. Nasojejunal feeding in low birthweight infants. *J Pediatr* 1975; **87**: 276-9.
- 2 Beddis I, McKenzie S. Transpyloric feeding in the very low birthweight (1500 g and below) infant. One year's experience in an intensive care neonatal unit. *Arch Dis Child* 1979; **54**: 213-7.

Intractable diarrhoea of infancy and latent otomastoiditis

Sir,

Dr Dodge's commentary has encouraged me to report my own experience in the same field as Salazar de Sousa *et al.*¹ The connection between intractable diarrhoea and latent otomastoiditis is well known here also. In the 1930s several articles were published about it in Hungary.

After treatment using fluid and electrolytes had been introduced, we found² that if an infant failed to recover after rehydration therapy latent otomastoiditis should be considered. However, an immediate operation resulted in rapid improvement in the patients.

After the second world war latent otomastoiditis with diarrhoea was common. At that time our patients were dystrophic and their general condition was poor as a result of lack of appropriate infant food, unsatisfactory factory hygiene, and the inexperience of parents. This also accounted for the fact that the late mortality rate in infants was 10 times higher than it is now. Salazar de Sousa *et al.*¹ mentioned that their patients also suffered from malnutrition.

For 15-20 years, no such patient has presented and thus latent otomastoiditis has almost disappeared. However, it should not be forgotten, and we are grateful that our attention has been drawn to this problem.

References

- 1 Salazar de Sousa J, Da Silva A, Da Costa Ribeiro V. Intractable diarrhoea of infancy and latent otomastoiditis. *Arch Dis Child* 1980; **55**: 937-40.
- 2 Kalmár I, Boda D. Otologic concern of infantile dehydration treated with continuous intravenous drip infusion (in Hungarian). *Orvosi Hetil* 1952; **93**: 121-3.

DOMOKOS BODA
Paediatric Department,
University School of Medicine,
Korányi fasor 18,
H-6725, Szeged, Hungary

Sir,

It is well known that latent otomastoiditis is one cause of failure to thrive, and so too, although less often, is it a cause of diarrhoea. Its disappearance from paediatric literature was only temporary. Referring to the paper by Salazar de Sousa *et al.*¹ we wish to draw attention to the following aspect of otitis and diarrhoea.

In Peru malnutrition is common in infants and children and all necropsies on children who had suffered from severe malnutrition showed latent otomastoiditis. A number of infants in hospital with severe malnutrition was carefully examined; about two-thirds also had diarrhoea, partly meeting the criteria of intractable diarrhoea. No normal antromastoid x-ray film was found in the entire group, and all leucocyte counts were normal. Antrotomy was performed on a few patients and the remainder were treated for malnutrition only, firstly by parenteral and, later, by oral refeeding. This resulted in recovery from both otitis and diarrhoea, and consequently we feel that diarrhoea and otomastoiditis can be two unrelated sequelae of a single cause—malnutrition. As Salazar de Sousa *et al.* gave no precise details of the nutritional status in his patients, malnutrition before the onset of severe diarrhoea seems possible. However, leucocytosis in these cases could suggest a different pathogenesis.

Reference

- 1 Salazar de Sousa J, Da Silva A, Da Costa Ribeiro V. Intractable diarrhoea of infancy and latent otomastoiditis. *Arch Dis Child* 1980; **55**: 937-40.

P ALARCÓN AND G GRANDITSCH
University Children's Hospital Vienna,
Währinger Gürtel 74-76,
A-1090 Wien, Austria

Professor Salazar de Sousa comments:

I agree that failure to thrive (without diarrhoea) may be associated with latent otomastoiditis. Recently we had a patient in whom antrotomy showed an ear infection and was followed by rapid weight gain.

The necropsy findings in severely malnourished Peruvian infants are not surprising, since they are similar to the findings of Parrot.¹ The possibility of spontaneous healing of latent otomastoiditis was shown by Lévesque *et al.*² by means of diagnostic and sequential needle aspirations of the antrum in infants who recovered without need of antrotomy. It must be admitted that an unknown, but high proportion of infants suffering from malnutrition, diarrhoea, and latent otomastoiditis may recover only with medical treatment. However, other patients did not tolerate ear infection so well and they present a remarkable resistance to treatment; their recovery is dependent on antrum surgery.³ Our present experience with such infants is confined to 16 cases, 13 of whom were submitted to antrotomy. In each of the 11 survivors the response to surgery was the same: clearing of diarrhoea within 4 days, disappearance of fever (when present) the following day, and rapid weight gain. In these cases clinical improvement is unlikely to have been