pyloric stenosis in Belfast continued to fall⁴ and two patients were submitted to operation but no really convincing tumour was found. Perhaps, with our tongues firmly in our cheeks, we could suggest to Professor Meadow that he leaves future palpations to his colleagues if he wants to preserve his 100% record.

References

- ¹ Knox EG, Armstrong E, Haynes R. Changing incidence of infantile hypertrophic pyloric stenosis. *Arch Dis Child* 1983;**58**:582-5.
- ² Webb AR, Lari J, Dodge JA. Infantile hypertrophic pyloric stenosis in South Glamorgan 1970-9. *Arch Dis Child* 1983;**58**:586-90.
- ³ Dodge JA. Infantile hypertrophic pyloric stenosis: definition, physiology and genetics. In: Rotter JJ, Samloff IM, Rimoin DL, eds. *The genetics and heterogeneity of common gastrointestinal disorders*. London: Academic Press, 1980:419-90.
- ⁴ Dodge JA. Infantile hypertrophic pyloric stenosis in Belfast 1959-69. *Arch Dis Child* 1975;**50**:171-8.
- ⁵ Wallgren A. Is the rate of hypertrophic pyloric stenosis declining? *Acta Paediatr Scand* 1960;**49**:530-5.

Moist air and laryngotracheitis

Sir,

I thought that the main purpose of moistening air for

children with laryngotracheitis¹ was to take over the function of the nose which invariably malfunctions or is sidetracked.

Reference

- ¹ Henry R. Moist air in the treatment of laryngotracheitis. *Arch Dis Child* 1983;**58**:577.

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Dr Henry comments:

Dr Beekman has sidetracked himself by speculation about how mist therapy might conceivably help children with laryngotracheitis. The real issue to address is whether this treatment has any practical benefit. As I stated in my article, treatment with cold mist is unpleasant, does not always increase the amount of water enriched gas reaching the airway, and has never been shown to be of clinical benefit. A warm, moist atmosphere overcomes the disadvantages of cold mist but is also of unproved efficacy.

Moist air is widely used to manage children with croup and we need to resolve whether it is effective.