that time. Because of this reflex we doubt the efficacy of screening boys for undescended testes at 1 year and at school entry. The figures from Tamhne *et al* confirm our opinion that too many boys will be operated on unnecessarily because of retractility of the testes.

In 1989 a retrospective cohort study concerning the localisation of the testes from birth until puberty of 853 boys born in 1973 and living in West Friesland (The Netherlands) was done. In this study, which has been submitted for publication, we found a considerable number of boys with one or two undescended testes, that when previously measured, had been registered as scrotal. In all these boys the testes had assumed a normal scrotal position at puberty. This supports our advice that if the testes were descended no further screenings are necessary.

We agree with Tamhne *et al* that there is a need to set clear guidelines for the diagnosis of undescended testes and for referral pathways. This is important especially to prevent unnecessary operations.

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Revised criteria for diagnosis of coeliac disease and medical audit

SIR,—In the recently published revised criteria from the European Society for Paediatric Gastroenterology and Nutrition (ESPGAN) for the diagnosis of coeliac disease,¹ emphasis has shifted from the need for repeated biopsies to the response to dietary gluten withdrawal, combined with initial histological appearance of the jejunal biopsy.

It might be thought that this could decrease the use of this unpleasant and time consuming diagnostic procedure. However this may not be the case.

As part of a medical audit programme the clinical and histological details of jejunal biopsies performed in the Royal Liverpool Children's Hospital between January and May 1990 were reviewed.

Analysis of the data showed: (1) Out of 46 attempted biopsies, 10 were initially unsuccessful. (2) Of the 36 children biopsied, only four biopsies were performed after a gluten challenge, the rest were for initial diagnosis. (3) The number of jejunal biopsies for the first five months of 1990 was similar to the whole of 1989 (36 v 39) yet proportionately more children started a gluten free diet (11/36 (30%) v 10/39 (25%)). (4) Children referred from an outlying hospital were more likely to have a biopsy specimen compatible with coeliac disease (50% v 25%). (5) Eleven children commenced a gluten free diet, but only six had the characteristic 'flat' small intestinal mucosa of coeliac disease.

It was concluded that: (1) There was a significant chance of procedural failure with jejunal biopsy in children. (2) Few biopsies were performed after gluten challenge indicating that the practice of diagnosing coeliac disease by repeated biopsies had already lapsed.² (3) The increased number of biopsies in 1990 reflected a more aggressive diagnostic approach. (4) Gluten free diet was often commenced in the absence of characteristic histological criteria. With the new criteria these children would require gluten challenge.

It is therefore to be hoped that the use of the revised ESPGAN criteria will reduce dependency upon multiple jejunal biopsies and the inappropriate use of gluten free diet as highlighted by our medical audit.

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- 1 Report of the Working Group of the ESPGAN. Revised criteria for the diagnosis of coeliac disease. *Arch Dis Child* 1990;65:909-11.
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Crohn's disease

SIR,—Dr Puntis and colleagues have reported in this journal the first case of granulomatous lung involvement in a child with Crohn's disease.¹ It is clear from many previous reports that pulmonary involvement is actually common in chronic inflammatory bowel disease, although only a minority of patients have symptoms or overt signs. Bonniere and colleagues have demonstrated, in 22 adults with Crohn's disease who had no pulmonary symptoms, reduced serum activity of angiotensin converting enzyme, lymphocytosis on bronchoalveolar lavage, increased superoxide anion production from activated alveolar macrophages, and abnormal pulmonary function tests.² They concluded that most patients with Crohn's disease have latent pulmonary involvement. After recent findings in this unit, we are now able to suggest a mechanism for this previously unexplained phenomenon.

We have demonstrated production of the cytokine tumour necrosis factor- α (TNF- α) by single macrophages in colonic biopsies from patients with both Crohn's disease and ulcerative colitis,³ and have found raised serum concentrations of TNF- α in patients with relapsed colonic disease⁴; we consider that chronic TNF- α elevation may contribute to anorexia and growth failure. TNF- α has also been implicated in granuloma formation⁵; granuloma epithelioid cells are in fact activated and transformed macrophages. TNF- α mRNA was found in large quantities within these experimentally induced hepatic granulomas and anti-TNF- α monoclonal antibodies caused both rapid granuloma regression and reduction of TNF- α mRNA content.

TNF- α production is actually increased by exposure of macrophages to TNF- α itself,^{5,6} so that chronic elevation of serum TNF- α might lead to TNF- α production by tissue based macrophages. Pulmonary alveolar macrophages produce several times more TNF- α on stimulation than do circulating monocytes,⁷ and we suggest that raised serum TNF- α concentrations in chronic inflammatory bowel disease could stimulate alveolar macrophages to produce more TNF- α , which

would then act within the pulmonary micro-environment.

It is now clear that TNF- α can cause lung damage, and it is viewed as an important mediator in the adult respiratory distress syndrome (ARDS), which frequently supervenes in conditions such as septicaemia where serum TNF- α concentrations are grossly raised. Alveolar lavage fluid contains measurable TNF- α of pulmonary origin in ARDS.⁸ Lesser elevation of serum TNF- α produces a more subtle derangement of pulmonary function, demonstrated well by the abnormal lung function tests found in patients treated for malignancy with recombinant TNF- α .⁹

We think that this mechanism would account for the activated alveolar macrophages found by Bonniere *et al*,² for the subtle lung function abnormalities found in many patients with active disease, for pulmonary granuloma formation, and for the more florid ARDS like picture found in many patients with life threatening toxic dilatation, where serum TNF- α may be much higher.⁴

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VIDEO REVIEWS

The Six Week Check of Infants. A video training package. Commissioned by: Nottingham Health Authority. Production Company: Chrysalis Television Midlands. Cost of training package (video and manual): £195; additional trainer's manuals £6 each. For details contact: Mrs B Whitchurch, Training Office, Notting-

ham Health Authority, Community Unit, Memorial House, Standard Hill, Nottingham NG1 6FX.

This package provides a very good basis for training sessions for general practitioners and other health care workers involved or becoming involved in child health surveillance. It should prove useful for both initial training and for update sessions for more experienced practitioners. The video consists of four parts (introduction, communication skills, the examination, and outcomes) plus an 'activity' 18 slides of situations likely to be found during a surveillance check, where the participants are requested to write down the action they would take. There are two other activities based on sections of the video and very useful handouts, together with an evaluation form to complete the half day session. The package is designed to be highly interactive and to accommodate participants coming from varied levels of experience. It can be used flexibly with modifications to suit local needs.

The quality of the video varies from fair to excellent. Some of the slides used in the 18 situations section and elsewhere are of poor quality rendering interpretation difficult. There are some inconsistencies in the presentation, inevitable in such an unevaluated and rather controversial area of child health practice. The lack of agreement on terminology is discussed. In one section 'the doctor' who appears to be either a clinical medical officer or already a general practitioner doing surveillance is advised to sit down and discuss her findings with 'the health visitor' and with 'the GP' (a person who appears in another section of the tape as the link worker). Some may find the slightly patronising and proselytising approach of the presentation somewhat irritating especially the rather protracted section on the need for good communication.

Overall, however, the package is well thought out, well presented, and well worth buying for departments undertaking training in child health surveillance.

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The School Entrant Review. A video training package. Commissioned by: Nottingham Health Authority. Production Company: Chrysalis Television Midlands. Cost of training package (video and manual): £195; additional trainer's manuals £6 each. For details contact: Mrs B Whitchurch, Training Office, Nottingham Health Authority, Community Unit, Memorial House, Standard Hill, Nottingham NG1 6FX.

However much paediatric experience the newcomer to community work may have, some time must be devoted to teaching the particular skills of the trade. This tends to follow the time hallowed industrial principle of 'sitting by Nellie' for a few sessions until deemed ready for useful work (not wishing to offend the one and only Nellie, listed on page 45 in current BPA handbook, by whom any aspirant community paediatrician would be well advised to sit; she cannot be expected to provide for the whole country). Properly organised classroom instruction in basic as distinct from the leading edge aspects of the craft remains rare. The ever innovative Nottingham department of community paediatrics has done us all a service in designing a course of

instruction for both medical and nursing recruits to school health based around an instruction manual for the organisers, work sheets for participants, and a 45 minute, four part video. The course contains important lessons too for old stagers (your reviewer included) who could be subtly updated by exposure to this training package in the role of trainer. Selected parts of the package would be useful for teachers because it could help them to see what the school health service is all about and how they can work cooperatively with us. The same applies to school governors.

The trainer's manual tells one how to lay on the course, the equipment and type of venue needed, when to break for coffee, and the families one will need to recruit for demonstration purposes. The course starts with a historical overview of school health: where it came from, what it does now, and exposes the group to the current debates about its future, tending to side with preservation of the status quo, which should be taught to all paediatricians in training whatever their discipline. Carried out conscientiously, with first rate instructors, and good organisation, the manual on its own would form the basis of an excellent course. Video is a very powerful teaching tool; it is easy for armchair critics to carp and forget that it is exceedingly difficult to make well and expensive to accommodate second thoughts. I am glad that real professional staff and families were used instead of actors. I did not like all the messages and examples given, and although she was an excellent role model, would criticise the doctor's excessive use of leading questions. The manual goes into 'questioning techniques' in some detail and if used properly should correct this fault. I do not think that examining the upper abdomen of children who are standing up is good practice and it is a pity that testicular examination was not shown. The video, however, is only part of the course and local tutors are expected to expand on these points. The manual will be easier to modify in the light of experience as opposed to the video.

The school nurse in the video sat in the background and in real life I hope that she would have used her time more productively. The weighing scales used (£7.50 when I last visited Asda) take economy and inaccuracy to extremes. As long as points of this type are recognised and discussed no harm will result. What must not be done is to lend the video on its own to a new recruit to take home. It will be the intelligent use of the manual and the resulting group dynamic that will make or break this course; the video is a supplementary basis for discussion.

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BOOK REVIEWS

Chronic Childhood Disease—An Introduction to Psychological Theory and Research. Christine Eiser. (Pp 174; £25.00 hardback, £8.95 paperback.) Cambridge University Press, 1990. ISBN 0-521-38519-9 (h/b), 0-521-38682-9 (p/b).

Every so often there is a piece of work bringing together research and thinking on a subject and acting as the source of reference for the next few years. In 1965 Vernon and colleagues published a comprehensive survey of literature on the effects of hospitalisation and illness in childhood.¹ Ten years later Pless and Pinkerton not only collected and sifted the literature on the psychology of chronic childhood disease, but began to provide a conceptual model of adjustment and maladjustment of the child with a chronic disorder in his family and society.² In the same year the psychologists Rachman and Phillips, in a brief but encouraging description of ways in which psychologists had already applied their skills to the problems of medical conditions and treatments, wrote one of the first tentative calls to clinical psychologists in Britain to turn their own attentions to the field of medicine.³ Now Christine Eiser demonstrates how far the psychologists have come in the last 15 years in one area alone: the psychological effects of chronic disease on children and their families.

This book reviews and draws together the results of well conducted studies, and emphasises the relevance for clinical practice. Throughout, the emphasis is on children's illness and treatment experiences in the context of their development, and other aspects of their social lives. The book is kept to a reasonable length by largely excluding the major motor disabilities, blindness, deafness, and mental handicap.

The contents cover hospitalisation and pain management and the effects of chronic disease on educational achievement, self esteem, behaviour, and family life and other relationships. The developmental approach is exemplified in the discussion of the development of concepts about the body, illness, and death and the consequent importance of appropriate communication of information to sick children of differing ages to aid their realistic understanding and contribution to compliance with treatment regimes. Chapters on the encouragement of coping strategies, and important issues which may inform and determine future research, round off this comprehensive review.

This book stands a good chance of becoming the source book on the psychology of chronic childhood disease, at least until Christine Eiser needs to bring it up to date.

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- 3 Rachman SJ, Phillips C. *Psychology and medicine*. London: Temple Smith, 1975.

Pediatric and Adolescent Gynecology. 3rd Ed. By SJH Emans, DP Goldstein. (Pp 621; £35.00 paperback.) Churchill Livingstone (Little, Brown), 1990. ISBN 0-316-23399-4.

Confronted with ever increasing requests for advice on children and adolescents with genital signs and symptoms: I need this book.

A paediatrician and a gynaecologist have successfully collaborated to produce a sensible and sensitive guide to the common and important gynaecological problems of childhood and adolescence. It is written in a refreshingly