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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- 1 Kelnar CJH. Treatment of the short, sexually immature adolescent boy. *Arch Dis Child* 1994; 71: 285-7.
- 2 Zinn C. Victims of Creutzfeldt-Jakob disease prompt code of conduct. *BMJ* 1994; 309: 1321.

Dr Kelnar comments:

I am grateful to Professor Boyd for his comments on my annotation. I hope that I emphasised 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.¹

Selective and appropriate hormone treatment is not designed to 'narrow the range of normality' (nor will it do so) but to relieve distress.² The extent to which it achieves that must also be 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 Boyds' 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.

- 1 Brown DC, Butler GE, Kelnar CJH, Wu FCW. A double blind, placebo controlled study of the effects of low dose testosterone undecanoate on the growth of small for age, prepubertal boys. *Arch Dis Child* 1995; 73: 131-5.
- 2 Kelnar CJH. Pride and prejudice – stature in perspective. *Acta Paediatr Scand (Suppl)* 1990; 370: 5-15.

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 is used to treat male pattern baldness.¹ It has been tried, unsuccessfully, to modify acute hair loss during chemotherapy²; 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's experience in alleviating this distressing side effect.

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- 1 Savin RC, Alton AV. Minoxidil: update on its clinical role. *Dermatol Clin* 1993; 11: 55-64.
- 2 Granai CO, Frederickson H, Gajewski W, Goodman A, Goldstein A, Baden H. The use of minoxidil to attempt to prevent alopecia during chemotherapy for gynaecological malignancies. *Eur J Gynaecol Oncol* 1991; 12: 129-32.

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 normal, then there is little to be gained by proceeding to contrast studies.

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- 1 Green MR, Southern KW, Wolfe SP, Littlewood JM, Najmaldin AS, Wyatt JL. Colonic strictures in cystic fibrosis [Letter]. *Arch Dis Child* 1995; 72: 191.
- 2 Smyth RL, van-Velzen D, Smyth AR, Lloyd DA, Heaf DF. Strictures of ascending colon in cystic fibrosis and high-strength pancreatic enzymes. *Lancet* 1994; 343: 85-6.
- 3 Taylor CJ. Colonic strictures in cystic fibrosis. *Lancet* 1994; 343: 615-6.

Dr Green and coauthors comment:

We agree that bowel ultrasonography has a place 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 Carty'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 or a colonic stricture 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 sew-on 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 use. 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 the care of these children to reject this approach and concentrate on working with schools and parents to support these