References


Addendum

Since submitting this paper four more infants have presented with intractable diarrhoea and latent otomastoiditis. Antrotomy showed bilateral mastoiditis in each, with osteitis in two. Cultures from the ear cavities grew a Klebsiella sp. in one and were negative in two. After surgery, diarrhoea stopped within 4 days and weight improved rapidly.

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Commentary

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Intractable diarrhoea of infancy as defined by Avery et al.1 is a fairly rare but a disproportionately resource-consuming problem in the UK. Although many contributory factors have been identified, the underlying aetiology is often obscure and management is reduced to life support by intravenous feeding and gradual weaning on to a hypoallergenic diet when possible. The mortality rate is high.

I have no personal experience of an association between this condition and subclinical mastoiditis or antral infection. It may be argued that I have never looked for it, and this would be perfectly true. Professor Salazar de Sousa claims that response to myringotomy was striking and that the procedure itself was relatively trivial. Most British paediatricians trained in the antibiotic era will have had little experience of myringotomy, although it was widely practised in North America where I worked 15 years ago. Perhaps if we looked carefully at necropsy for chronic middle ear infection in these babies we should find it. Perhaps too, if we took our courage in our hands, or in those of our ENT colleagues, we might also find that latent middle ear infection was often present in babies with intractable diarrhoea. Rapid recovery of the patient from his diarrhoea would be gratifying and would support Professor Salazar de Sousa’s claims. Perhaps some readers of the Archives have had similar experiences, and I know that the Editors would welcome correspondence.

Reference