count. There was then gradual deterioration in serial histological, cytological, and enzymological appraisals, with an almost flat mucosa at 63 months, and a flat mucosa at 74 months. Two years later, after returning to a gluten-free diet, the mucosa was normal in all respects (unpublished observation). This course of events clearly showed gluten intolerance, remission on a gluten-free diet, gradual mucosal relapse over a period of 74 months on normal diet, and a second remission on a gluten-free diet, the total time span being 13 years. Unless coeliac disease is not a homogenous entity, this girl unquestionably has coeliac disease but with a slow mucosal response to gluten ingestion, and the '2-year rule' if applied to her would have been misleading. It should not be surprising to find a spectrum of mucosal and clinical response to gluten ingestion, from very rapid to slow, as part of natural biological variability, and also perhaps related to differing responses at different ages.

We are worried by the statement concerning children in whom 'no adverse response to gluten occurs after 2 years of reintroduction', and the remark that 'Some, perhaps the majority, will rightly be considered to have had "transient" intolerance which is now cured, and will be discharged from the clinic'. 'Adverse response' is not defined, and apart from our belief that the '2-year rule' will not be valid for all coeliacs, we are emphatic that absence of an adverse clinical response alone after 2 years on gluten does not exclude coeliac disease, since we have evidence to the contrary. Rather than suggesting, as McNeish and colleagues do, that any patient with a normal mucosa after 2 years on gluten may be followed up by research workers only, we believe that any such patient should be carefully followed for several years, with biopsies at intervals of 12 to 24 months, and counselled to return for further investigation in the event of any form of ill health. Only in this way can the occasional slow and late mucosal relapse be detected, and subsequent illness be prevented.

We also question the need for gluten challenge in a child in whom a flat biopsy has been found who has not had acute enteritis, cows' milk intolerance, or IgA deficiency, and who responds to a gluten-free diet. The aim of gluten challenge in such children is to detect the 5% or so (as judged by the results of the ESPGAN questionnaire and our own trials) who will not have a mucosal relapse after 2 years on normal diet. Rather than subject each child thought to have coeliac disease according to these criteria to a gluten challenge and a minimum of 2 biopsies, we advise a gluten-free diet for an indefinite duration, with regular clinical review, and biopsies at 5-yearly intervals throughout life, or whenever there is clinical suspicion of a mucosal relapse. In the natural course of events, many patients will be found to have morphological, cytological, or enzymological evidence in biopsies which will indicate persisting gluten intolerance, thus providing the same information that an earlier postdiagnosis gluten challenge would have done. (Even if a postdiagnosis challenge has confirmed gluten intolerance, we believe that regular mucosal surveillance is still indicated in an attempt to ensure as normal a mucosa as possible, by means of continued gluten abstinence.) Any child who reaches early adult life with a mucosa which appears normal in all respects can then be offered a gluten challenge which, according to a recent study, may demonstrate persisting gluten intolerance more decisively, than a similar challenge in childhood.

This policy may result in a small percentage of children remaining on a gluten-free diet unnecessarily during adolescence, but with our present uncertainty about the ultimate state of tolerance to gluten in children presenting with flat intestinal biopsies, this may not be a bad thing. A precise understanding of the pathogenesis of gluten enteropathy and a reliable noninvasive method of identifying it in all patients might, as McNeish and colleagues imply, render much or all intestinal biopsies in such patients unnecessary.

References

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Professor McNeish and co-workers comment:
We thank Professor McNicholl and his colleagues for their comments. Professor McNicholl was one of the respondents to the coeliac questionnaire and he made valuable contributions to the discussions that followed in 1977. We hope that he recognises something of himself in our summary.

The further details that he and his colleagues have supplied on a late relapsing coeliac child are of great interest and confirm our contention that, although relapse within 2 years of reintroduction of gluten may be the rule, there are likely to be rare exceptions.

Professor McNicholl and colleagues make a plea that all who do not relapse after 2 years of gluten challenge should be followed indefinitely to exclude late relapses. We agree with this, but suggest that such patients should be grouped and studied by teams who have a particular research interest in the problem. For the practising paediatrician who has such a case, the important practical point after 2 years of uneventful gluten ingestion is to review critically the original diagnostic criteria on which the diagnosis of coeliac disease was based, and to attempt to estimate the amount of gluten likely to have been ingested during the challenge period.
We agree that an 'adverse response' to gluten must be measured by changes in intestinal mucosal morphology. We are glad to be able to stress this, because an absence of symptoms cannot be equated with a lack of response to gluten.

We do not agree that gluten challenge is unnecessary in an infant with a flat biopsy who has not had acute enteritis, cows' milk intolerance, or IgA deficiency, and who responds to a gluten-free diet. Our clinical acumen is not as great as that of our Irish colleagues, and it is in such infants that we have difficulty in making a firm retrospective diagnosis of coeliac disease.

Lastly, the timing and technique of gluten challenge that Professor McNicholl and his colleagues use is only one of several apparently satisfactory regimens. We agree that there is the need for more precise definition of a positive response to gluten challenge, and that this need will remain until the 'cause' of coeliac disease is known.

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Technique for facilitating tendon reflexes in children

Sir,

I do hope that Dr Varcasia's technique for eliciting tendon reflexes in a child by making him gag with a tongue depressor during examination of the throat \(^1\) will not become a common practice.

Any paediatrician who examines children will, one hopes, have learned at his mother's knees or will know instinctively that the most painful and distressing part of any examination should be left until last, and that no painful or distressing procedure should be used unless it can be justified. The picture of a child sobbing from this assault while the doctor attempts to obtain the errant reflex has elements both of tragedy and comedy. The suggestion that the assault be made by the mother seems particularly unpalatable, especially as this would appear to thwart the primary purpose of the throat inspection—to allow the doctor to see the throat and observe palatal movement.

One of the pleasures of working with children is that the doctor can allow himself to regress and to be a little childish. It is seldom difficult to obtain the co-operation of a child in reinforcing the reflexes by a variety of devices. Most children will happily squeeze their parent's finger, or even the doctor's, often taking an aggressive delight in doing so, and this will generally bring up a knee jerk which has been sluggish, if it is capable of being reinforced. A squeaky toy or rubber ball may be squeezed with the same effect, or the child can be persuaded to bite strongly on a sweet (jelly-babies are particularly useful since the child enjoys the symbolic make-believe).

Anxiety and tension will normally elicit tendon jerks, but many would consider the cost too high. An adequate neurological examination can be obtained in most children without upsetting them, or the doctor. This should surely be the aim to strive for.

Reference


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Dr Varcasia comments:

I agree that no unjustified distressing procedure should be used and I also agree that distressing parts of the examination should be left until last, but I am unable to conceive as an assault any part of the examination of a child. I think that paediatricians must perform with gentleness any unpleasant manoeuvre that is necessary.

My technique for eliciting tendon reflexes is easy, rapid, and is nearly always successful; I use it only if other manoeuvres have failed or if I have not obtained the co-operation of the child. Consequently I think that my technique will not become common practice, but I do not see in it elements either of tragedy or comedy.

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Lomotil in diarrhoeal illnesses

Sir,

I was disturbed by the suggestion made by Dr Karan and Dr Limaye that Lomotil might have a place in the treatment of childhood diarrhoea in the tropics, and was