Correspondence 577

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 Varcaasia's technique for eliciting tendon reflexes in a child by making him gag with a tongue depressor during examination of the throat1 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 Varcaasia 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 it in 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 Limay1-2 that Lomotil might have a place in the treatment of childhood diarrhoea in the tropics, and was
Correspondence

578

Dr Goel appeared to concur, albeit reluctantly. Certainly the management of diarrhoea in developing countries will not be the same as in developed countries, but the central element is still fluid therapy. Dr Karan and Dr Limaye offer no evidence that Lomotil will reduce the morbidity of this severe disease, nor even that it will shorten its course. Fluid loss is of much greater importance than intestinal motility and the lack of efficacy of Lomotil in reducing frequency of bowel movements and the water content of the stools in acute childhood diarrhoea has been documented. The essential role of oral hydration in its management in all countries has been widely discussed. It is strange that Dr Karan asserts ‘where children have no access to fluid therapy, symptomatic control becomes important’, when surely a home-based electrolyte mixture is more readily available, and is safer and more effective than Lomotil. A glucose electrolyte solution can be made up correctly by mothers at village level, and has a striking effect on mortality. In this climate of opinion propaganda in favour of symptomatic control of a killing disease seems at the least unwise.

References


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Dr Goel comments:

There is no disagreement that the mainstay of treatment of childhood diarrhoea in any part of the world is correction of dehydration and electrolyte acid-base status and not the use of an antidiarrhoeal drug such as Lomotil. Of course, as indicated by Dr Waterston, any mother, whether from a developing or a developed country, can correctly make a glucose-electrolyte solution for oral therapy. However, one should remember that oral therapy is effective only in a child with slight or moderate dehydration. In a severely dehydrated child intravenous fluid therapy is mandatory, especially if he is not retaining fluids orally, and such therapy may often be unavailable in more remote areas of the tropics.

As far as the use of Lomotil in tropical diarrhoea is concerned, I merely acquiesced in the statement of Dr Karan and Dr Limaye on their experience.

K M GOEL
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Dr Karan comments:

In response to Dr Waterston’s letter, I do not think that there is any argument about fluid therapy being an important element in managing diarrhoea, but I am equally disturbed at his suggestion that Lomotil has little place in managing tropical diarrhoea.

Lomotil is no substitute for oral fluids, but it is of symptomatic value in decreasing diarrhoea at least in the tropics, whether children have been given fluids or not. Field cited by Dr Waterston himself stated ‘Oral glucose-electrolyte therapy, however, does not decrease diarrhoea’, and our own study cited in earlier correspondence showed that in a control group given fluids alone the diarrhoea was not controlled as effectively as in the three groups given varying doses of Lomotil in conjunction with fluids. The Wilcoxon method of analysis and the permutation test showed that all three Lomotil groups in our study had diarrhoea for a significantly shorter time than the group given fluids alone (P<0.001).

Other workers in India and Africa have shown that Lomotil reduces the frequency of bowel movements (in many cases within 24 hours) in tropical diarrhoea and is safe if used as recommended, despite Portnoy’s evidence to the contrary, cited by Dr Waterston. Incidentally, that study showed 12 of 39 cases to be of parasitic origin, and in 27 cases no stool culture results were available. Lomotil can hardly be of value in parasitic infections. Portnoy himself stated ‘...it is difficult to evaluate the meaning or usefulness of stool water content determinations in the study of diarrhoeal illness’.

Finally, I should like to stress that we do encourage the use of oral fluids, and are fully aware of their beneficial effect on mortality. However when oral fluids are made up in rural areas there is a great danger that the solution will be too concentrated or too diluted, as outlined by Sedgwick and Cutting.

We recommend that under such conditions Lomotil should be given judiciously in conjunction with fluids. We know that the drug is no panacea but it plays a valuable role in acute non-specific diarrhoea, at least in the tropics.

References