birthweight; in 3 out of 4 babies in whom I attempted to pass the tube the tip lodged in the first part of the duodenum and would not negotiate the duodenal loop. It is possible that this difficulty could be overcome by using a tube with a shorter weight at the tip.

I have had no experience with NJ tube feeding in babies being mask ventilated, but Wells and Zachman\(^1\) and Beddis and McKenzie\(^2\) reported considerable difficulties and a high complication rate; this would seem to be a contraindication for transpyloric feeding.

References


Intractable diarrhoea of infancy and latent otomastoiditis

Sir,

Dr Dodge's commentary has encouraged me to report my own experience in the same field as Salazar de Sousa et al.\(^1\) The connection between intractable diarrhoea and latent otoantritis is well known here also. In the 1930s several articles were published about it in Hungary.

After treatment using fluid and electrolytes had been introduced, we found\(^2\) that if an infant failed to recover after rehydration therapy latent otoantritis should be considered. However, an immediate operation resulted in rapid improvement in the patients.

After the second world war latent otomastoiditis with diarrhoea was common. At that time our patients were dystrophic and their general condition was poor as a result of lack of appropriate infant food, unsatisfactory factory hygiene, and the inexperienced of parents. This also accounted for the fact that the late mortality rate in infants was 10 times higher than it is now. Salazar de Sousa et al.\(^1\) mentioned that their patients also suffered from malnutrition.

For 15–20 years, no such patient has presented and thus latent otomastitis has almost disappeared. However, it should not be forgotten, and we are grateful that our attention has been drawn to this problem.

References


Professor Salazar de Sousa comments:

I agree that failure to thrive (without diarrhoea) may be associated with latent otomastoiditis. Recently we had a patient in whom antrotomy showed an ear infection and was followed by rapid weight gain.

The necropsy findings in severely malnourished Peruvian infants are not surprising, since they are similar to the findings of Parrot.\(^1\) The possibility of spontaneous healing of latent otomastoiditis was shown by Lévesque et al.\(^2\) by means of diagnostic and sequential needle aspirations of the antrum in infants who recovered without need of antrotomy. It must be admitted that an unknown, but high proportion of infants suffering from malnutrition, diarrhoea, and latent otomastoiditis may recover only with medical treatment. However, other patients did not tolerate ear infection so well and they present a remarkable resistance to treatment; their recovery is dependent on antrum surgery.\(^3\) Our present experience with such infants is confined to 16 cases, 13 of whom were submitted to antrotomy. In each of the 11 survivors the response to surgery was the same: clearing of diarrhoea within 4 days, disappearance of fever (when present) the following day, and rapid weight gain. In these cases clinical improvement is unlikely to have been
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due to any factor other than antrotomy. In summary, we may have to deal with two sorts of infants: in the first, diarrhoea and latent otomastoiditis can be the unrelated sequelae of malnutrition and recovery from both can be achieved by nutritional improvement; in the second, latent otomastoiditis may perpetuate both the diarrhoea and the malnutrition and recovery be dependent on antrotomy.

I do not know why leucocyte counts were normal in the patients seen by Dr Alarcón but were consistently increased in ours. However, the relationship between leucocytosis and latent otomastoiditis was in no doubt, as shown by the rapid fall in leucocyte counts after antrotomy.

References