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Dr Garty and co-workers comment:

We appreciate the comments of Aguiar *et al.* Their observations further support our opinion on the non-specificity of the longitudinal grooves along the axis of the hair, as mentioned in our communication.[1]

We stated in our paper that:

(1) Not all the hair examined is abnormal.
(2) The finding of longitudinal grooves along the hair axis are not specific and have also been reported in progeria, in monilethrix, and in pili torti.[2]
(3) Longitudinal grooves were found in most of the hair examined. Ferrando *et al*, who examined 10 cases of uncombable hair, found longitudinal grooves in more than 50 out of 100 hairs in each case.[3]
(4) A triangular or oval section of the hair (a form which might be related to the longitudinal grooves) was also reported in mucopolysaccharidosis and in normal subjects.[2]

Moist air in the treatment of laryngotracheitis

Sir,

The suggestions expressed by Richard Henry[1] on the treatment of croup are rather illogical, particularly in the context of the North American scene. His general recommendations were that warm, moist air may be helpful and probably does not do any harm while cold, dry air and tents should be avoided since tents might be frightening and cold air makes exercise induced asthma worse.

I would like to make the following observations:

(1) A properly applied cool, vapourised tent need not be a frightening experience for an infant or a child. Initially, a parent can go into the tent with the child and one cannot help remarking that there does seem to be a definite improvement in most cases of spasmodic croup.

(2) Warm, moist air seems ineffective and may even cause a deterioration related to a possible increase in the hyperaemia of the laryngeal mucosa caused by the warmth itself.

(3) Cold air seems to be an important factor, and time and time again we have noticed that the simple manoeuvre of bundling a child and taking him to an open window or outside leads to a noticeable and rapid improvement.

The difference in approach may relate to the fact that houses in England tend to be cold, damp places (personal observation) whereas houses over here are hot, dry places. Control trials are possible even on this subject, but recommendations should take the appreciably different ambient environments on either side of the Atlantic into account.

Reference

[1] Henry R. Moist air in the treatment of laryngotracheitis. *Arch Dis Child* 1983;**58**:577.

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Overheating in infancy

Sir,

As C J Bacon writes in his valuable annotation,[1] overheating in babies may be disastrous. During a cold spell late in 1946, at a time of fuel shortage, the central heating was cut off at night in a London teaching hospital. In the children's ward a nurse placed two feeble babies next to a radiator and draped a blanket over it and their cots, to make use of residual heat. She did not notice when the heating was turned full on at 4 am so both babies died of hyperpyrexia.

Later that winter in another teaching hospital a healthy baby was born in the private block. Electric blankets were not allowed in the public maternity ward but the mother had brought her private nurse in with her and she brought an electric cot blanket. On the second night the nurse felt the baby and thought she was cold so she switched the blanket up to a higher heat level. In the morning the baby was convulsing uncontrollably and was hyperpyrexial. She died in the afternoon.

Reference

[1] Bacon CJ. Overheating in infancy. *Arch Dis Child* 1983;**58**:673–4.

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