obvious organic basis such as constipation or mesenteric adenitis, but one can see that this has been perpetuated by parental concern confirming and reinforcing the child's anxiety that there must be something seriously wrong. Successful management, as always, is dependent upon successful diagnosis. Thorough and confident reassurance and frank explanation are the cornerstones of treatment. Once the parents (and child) understand that abdominal pain may be perpetuated by anxiety and that a diagnosis of emotionally triggered pain does not mean that the family is labelled as uncaring or that the child is 'putting it on', the symptoms disappear. At follow up no such patient of mine has suffered further pain. I have no doubt that investigating them further in an attempt to provide a scientific, laboratory based diagnosis would not only draw a blank, as was the experience of McGrath et al, but would also enhance the view that something must be wrong if only it could be identified, and thus fuel the symptoms. The fact that all my patients in this group have been 'cured' by explanation supports my hypothesis better than any laboratory test could do.

References


Overheating in infancy

Sir,

The article by Dr Bacon 'Overheating in infancy' brings back fond memories of 'sweating the fever out' at boarding school in Trinidad. Innumerable blankets were piled upon one by the housemaster, usually of European origin, in the fond hope of releasing the fever.

Trinidad is a Caribbean island, situated just 10 degrees above the Equator and with an average annual temperature of about 80°F. Febrile convulsions account for 10% of all admissions to my paediatric unit at the Port of Spain Hospital. Yet it is difficult to teach mother and grandmother that wrapping up the baby and putting a woollen hat on its head will do more harm than good. Worms of course, are blamed for the fits. I am sure the experience is the same in all tropical countries.


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