References

[1] White RHR. Management of urinary tract infection. *Arch Dis Child* 1987;**62**:421–7.
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[3] McAlister WH, Cacciarelli A, Shackelford GD. Complications associated with cystography in children. *Radiology* 1974;**111**:167–72.

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Management of urinary tract infection

Sir,

In his Personal Practice paper,[1] Professor R H R White states that in the investigation of urinary tract infections by ultrasonography 'it is prudent to combine this procedure with a plain abdominal radiograph to exclude radio-opaque calculi and facilitate review of the lumbosacral spine'.

His yield of opaque calculi may be increased if he requests a plain abdominal radiograph after a drink—a technique most *x*-ray departments already use for improving the results of an intravenous urogram.

Reference

[1] White RHR. Management of urinary tract infection. *Arch Dis Child* 1987;**62**:421–7.

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The physically handicapped school leaver

Sir,

M Ann Chamberlain contributes a generous annotation[1] based on our pamphlet 'The health and social needs of physically handicapped young adults—are they being met by the statutory services'?[2] We must, however, correct one or two inaccuracies.

Chamberlain refers to the report as 'The Spastics' Society Report'. It was of course written by us and is not a report from the Spastics' Society, and certainly does not represent either their policies or necessarily their views. The views are our own.

In the penultimate paragraph she quotes the report as suggesting that we were proposing a sub specialist grade to treat adolescents. We were, in fact, careful not to do this. We talked about the setting up of a district based handicapped adult team and would agree with her view that an adult specialist needs to be appointed to take on this task.

References

[1] Chamberlain MA. The physically handicapped school leaver. *Arch Dis Child* 1987;**62**:3–5.
[2] Bax M, Coombes K, Goldson E, Smith D, Whitmore K. The health and social needs of physically handicapped young adults: are they being met by the statutory services? *Dev Med Child Neurol* [Suppl] 1985;**27**:1–20.

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Varioliform gastritis and campylobacter-like organisms

Sir,

We read with interest the report of a paediatric case of varioliform gastritis by Caporali *et al*,[1] supporting the idea that this endoscopic picture has an allergic aetiology. We have recently reviewed our upper digestive endoscopy findings in children retrospectively looking for histologic evidence of campylobacter-like organisms. Among children with histologic evidence of such infection of gastric mucosa we found a 9 year old girl who was admitted with anorexia, epigastric pain, and vomiting. Endoscopy showed typical scattered umbilicated papular lesions called varioliform gastritis in the antrum and the body of the stomach. Histological examination showed poly- and mononuclear infiltration in gastric specimens (fig 1) associated with the presence of bacteria under the mucus layer (fig 2). No evidence of in vivo or in vitro food allergy was found. Follow up of this patient was not possible because she moved to another country.

Recently campylobacter-like organisms were shown to be associated with gastritis, and gastric and duodenal ulcers both in adults and in children.[2] Even though a specific endoscopic picture has not been described, the occurrence of antral nodularity and histological gastritis has been found in children with this disease.[2 3] The

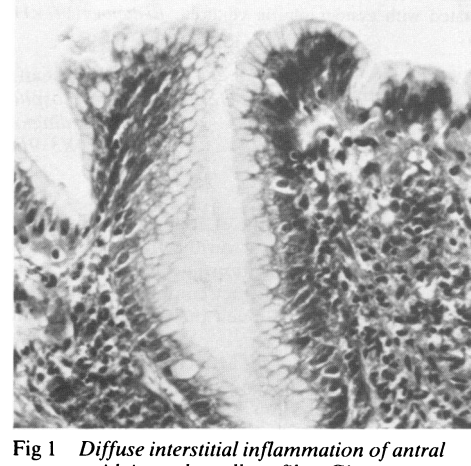

Fig 1 *Diffuse interstitial inflammation of antral mucosa with irregular cell profiles. Giemsa.*

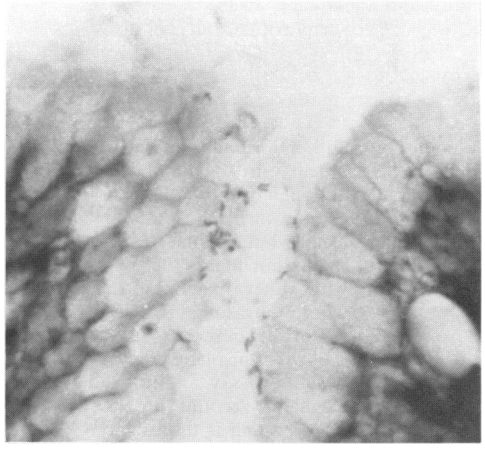

Fig 2 *At higher magnification numerous campylobacter-like organisms adhering to the luminar surface of foveolate epithelium. Giemsa.*

outcome of the infection in a child with dyspepsia but no ulcer varioliform gastritis might indicate that this peculiar endoscopic picture is probably not specific to a particular aetiology. As histological diagnosis of campylobacter-like infection is possible also on formalin fixed specimens if the Warthin-Starry or Giemsa stains are used, we suggest that the association between it and varioliform gastritis may be easily confirmed in a large series.

References

[1] Caporali R, Luciano S. Diffuse varioliform gastritis. *Arch Dis Child* 1986;**61**:405–7.

[2] Czinn SJ, Dahms BB, Jacobs GH, Kaplan B, Rothstein FC. Campylobacter-like organisms in association with symptomatic gastritis in children. *J Pediatr* 1986;**109**:80–3.

[3] Cadranel S, Goossens H, De Boeck M, Malengreau A, Rodesh P, Butzler JP. Campylobacter pyloridis in children. *Lancet* 1986;**i**:735–6.

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Haemorrhagic disease and vitamin K

Sir,

In their recent annotation[1] Tripp *et al* state their preference for using oral vitamin K_1 for routine prophylaxis against haemorrhagic disease of the newborn. They felt that convenience and acceptability to the parents were sufficient grounds for recommending a 1 mg dose to be given orally routinely unless there was evidence of the baby being at high risk of haemorrhagic disease. In support of this recommendation, they state that they have not seen any case of early or late haemorrhagic disease in 25 000 babies treated in this manner.

The experience in Sheffield using oral prophylaxis has been less satisfactory. Routine prophylaxis was introduced three years ago following a cluster of cases of late haemorrhagic disease occurring between three and seven weeks after birth. Two of the maternity units in the city use intramuscular, and the third unit uses oral prophylaxis. One of the babies who received 1 mg of vitamin K_1 orally in the labour ward subsequently developed severe haemorrhagic disease at 7 weeks of age. He was born at full term weighing 4100 g and was fully breast fed. He was completely well until he developed convulsions at 7 weeks of age due to an enormous intracerebral haematoma occupying the posterior half of the left hemisphere. He had severe vitamin K deficiency which was corrected rapidly with treatment. He has subsequently made a good recovery. He had no predisposing reason for the vitamin K deficiency, and his sweat test was negative. His mother was well throughout the pregnancy and received no drugs other than iron and vitamins.

Haemorrhagic disease has always been uncommon even without routine prophylaxis. The aim is to prevent an uncommon, but potentially fatal, disorder. We feel that vitamin K given intramuscularly is more likely to prevent this serious condition than if it is given orally.

Reference

[1] Tripp JH, McNinch AW. Haemorrhagic disease and vitamin K. *Arch Dis Child* 1987;**62**:436–7.

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Skin rashes after triple vaccine

Sir,

With regard to the article by Denning *et al*[1] on rashes after diphtheria-pertussis-tetanus (DPT) vaccine, I have seen an eczematous reaction concentrated around an aluminium granuloma following DPT, spreading to the trunk, but tapering off from the injection site. There was no history of previous eczema. I did not risk giving another DPT injection. An article in the *Practitioner* described similar skin reactions.[2]

References

[1] Denning DW, Peet L, Pool J. Skin rash after triple vaccine. *Arch Dis Child* 1987;**62**:510–1.

[2] Orlans D, Verbov J. Skin reactions after triple vaccine. *Practitioner* 1982;**226**:1295–6.

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