

associated with a significant morbidity, gastro-oesophageal reflux in the absence of this anomaly is a relatively benign self limiting condition, which in the case of vomiting infants can usually be treated successfully by appropriate and adequate thickening of feeds.⁴ I am therefore in no doubt as to the clinical importance of distinguishing infants with reflux and a partial thoracic stomach (in whom the antireflux contribution of the abdominal oesophagus is absent) from those with reflux as the only observed abnormality. Such reliance on the prognostic significance of a partial thoracic stomach is of course totally dependent on having an experienced paediatric radiologist as a colleague who is equally aware of the importance of carefully examining infants with reflux for a partial thoracic stomach.

I J CARRÉ
Le Val Farm,
Les Blicqs,
St Andrew's,
Guernsey,
Channel Islands

- 1 Milla PJ. Reflux vomiting. *Arch Dis Child* 1990; 65:996-9.
- 2 Carré IJ. The natural history of the partial thoracic stomach (hiatus hernia) in children. *Arch Dis Child* 1959;34:344-53.
- 3 Carré IJ. Clinical significance of gastro-oesophageal reflux. *Arch Dis Child* 1984;59: 911-2.
- 4 Carré IJ. Management of gastro-oesophageal reflux. *Arch Dis Child* 1985;60:71-5.

Growth after gut resection for Crohn's disease

SIR,—We read with interest the paper by McLain *et al*, and we would like to comment on both the methodology of their data collection and the authors' conclusions.¹ Firstly, this was a retrospective study, and thus has the major disadvantage of lacking standardisation in the collection of the auxological data. There is no mention in their paper of how height measurements were recorded and standardised, or on the accuracy of the staging of pubertal development.

Secondly, while agreeing with their findings that dramatic growth acceleration may occur after surgery for Crohn's disease, we disagree with their conclusion that 'catch up growth is not limited by the stage of puberty'. We have recently completed a large, prospective study investigating factors influencing growth after bowel resection for Crohn's disease in 42 children requiring surgery before their 17th birthday. All growth indices (including height measurements every three months) were performed prospectively by a clinical auxologist, and an accurate pubertal staging was performed in each patient at the time of surgery, together with the radiological bone age in the majority of cases. Our data (table) clearly show a strong relationship between height velocity in the first postoperative year and the pubertal status (Tanner breast and genital stage) at time of operation. The apparent lack of effect of pubertal status on growth in the study of McLain *et al* may merely reflect the very small number of children in advanced puberty (one), or the retrospective nature of their data collection. In our opinion, the timing of surgical intervention is vital, and should be performed before puberty becomes too advanced and the potential for catch up growth is lost. This is in direct contrast to the conclusion stated in their paper.

Finally, we monitor growth very carefully in all our children with Crohn's disease. Any

Mean preoperative and postoperative height velocities (cm/year) in 42 children undergoing bowel resection for Crohn's disease grouped according to pubertal status at time of operation

| | Boys | | Girls | |
|-------------------------------------|----------------|---------------|----------------|---------------|
| | Before surgery | After surgery | Before surgery | After surgery |
| Prepubertal: stage 1 (n=18) | 1.85 | 7.40* | 1.64 | 9.08* |
| Early puberty: stages 2 or 3 (n=14) | 2.81 | 8.20* | 2.23 | 7.14* |
| Late puberty: stages 4 or 5 (n=10) | 3.32 | 4.50† | 2.87 | 3.09† |

*p<0.0001, †p=not significant.

patient whose growth appears to be suboptimal is referred to a joint paediatric inflammatory bowel disease/growth clinic every three months, which is staffed by a paediatric gastroenterologist, a paediatric endocrinologist, and a clinical auxologist, to determine the appropriate strategy for managing the problem (for example, surgery) at an early stage.

C M EVANS
J M W KIRK
M O SAVAGE
J A WALKER-SMITH
Academic Department of Paediatric Gastroenterology
and Department of Child Health,
St Bartholomew's Hospital,
London EC1A 7BE

- 1 McLain BI, Davidson PM, Stokes KB, Beasley SW. Growth after gut resection for Crohn's disease. *Arch Dis Child* 1990;65:760-2.

Drs Davidson and Beasley comment:

Thank you for the opportunity to reply to the correspondence of Evans *et al*. We agree completely with their comments regarding the relationship of the timing of surgery to puberty on catch up growth in Crohn's disease. Although we acknowledge that we have insufficient patients in advanced puberty to comment on the effect on growth of the stage of puberty, our data would suggest that catch up growth is not limited by the onset (as distinct from stage) of puberty. The one patient in advanced puberty clinically who exhibited catch up growth after surgery did not have his bone age assessed.

Like Evans *et al* we would emphasise the importance of careful ongoing growth measurements in these children. The use of a multidisciplinary team provides optimal management of children with Crohn's disease.

Finally, we are pleased to find that the prospective data of Evans *et al* support our retrospective observation.

SPRING BOOKS

The paediatric departmental library

What should be the priority for the paediatrician when financial considerations reign and access to current literature is still via books and journals? The rate of change in paediatric practice and slowness of publication in journals and especially in textbooks lead to such a rapid obsolescence that departmental libraries

are rarely of use for any in depth study. They provide a source to back up basic case presentations but at a considerable expense. It is impossible to shortlist key titles as every paediatrician has a favourite selection of titles that have proved to be of particular value. These titles have often been selected because the paediatrician has been asked to review that particular book or because a particular subject caught his/her eye from browsing through the unsolicited mailed catalogues or at bookshops at conferences. Most medical schools are persuading departments to adopt a centralised library system for the sake of more efficient lending schemes and security. So what does the paediatrician provide for the juniors who rarely have time to reach the central and sometimes distant library?

There must be the equivalent of a paediatric encyclopaedia covering most common subjects, such as the *Textbook of Paediatrics* by Forfar and Arneil or Nelson's *Textbook of Pediatrics*. Then a selection of system or disease based textbooks should be available. The exact proportion of the subjects will depend on the case mix of the unit. Most general paediatricians will have these books but whether they can be maintained in their current editions is unlikely at present. A cheap but effective way of maintaining a more up to date reference for junior staff is to organise a file of review articles from paediatric journals or free journals such as *Hospital Medicine*, *Medicine International*, *Update*, *Hospital Update*, *Prescriber's Journal*, and *Drugs and Therapeutics Bulletin*. The difficulty is the archiving and security. However the availability of photocopiers has made this easier, although care must be taken to avoid infringing the copyright laws. Another very useful practice is to incorporate a photocopy of a key article in the hospital notes of the patient with this particular diagnosis. It is important to keep updating this and to include this article in the departmental 'useful literature' file. This filing system is unlikely to succeed unless it is clearly one individual's responsibility and that should be at fairly senior level.

However, we are on the brink of the breakthrough in data retrieval which has had the Medline searches and now the CD ROMs as forerunners. When the computer terminal is as familiar and essential an item on the desk in consulting room and ward alike, we will be able to access up to date original articles and learned reviews at the touch of a few buttons. I can foresee the time when as the medical details (plus accounting data) is entered into the consulting room computer an automatic search will be made for relevant new literature on that child's condition. A summary of this will be available for inclusion in the word processed report that will be available for any of the child's professionals to access, as well as for inclusion in the hardcopy that the parents will be carrying. So the medical library will pass into the mists of memory as the stockmarket runners have and as the filing rooms in hospital will.

GRAHAM CLAYDEN
Reader in paediatrics

A Paediatric Vade-Mecum. 12th Ed. Edited by Jack Insley. 12th Ed. (Pp 296; £13.95 paperback.) Edward Arnold, 1990. ISBN 0-340-52693-9.

Who needs a Filofax when he can have the vade-mecum? This remarkable little book must have a greater concentration of paediatric