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paid. The cost savings from non-transplanted livers were equally impressive even at the discounted price of £30,000 per transplant. Are we to believe that these spare livers would not be used for some equally deserving cases thus resulting in no net saving to the health service? As a paediatrician I remain unconvinced by the arguments advanced that a national screening programme for biliary atresia in newborn infants will detect all forms of hepatitis-biliary disorders. Mosaic will have other hepatitis-biliary disorders for which early and specific treatment is desirable. By screening at the same time as the infant is being assessed by community healthcare managers the cost and logistic difficulties will be minimised.

King's Healthcare Trust is undoubtedly in the real world. Next year the cost for a direct biliurin will increase to £4.00 including all overheads! Since these two-week infants and children in UK died while on waiting lists for liver transplantation. If any of these were alive because a selective screening made transplantation unnecessary for one child with biliary atresia, would any paediatrician object?

Because the optimum time for screening is controversial, community staff in our district are testing for conjugated hyperbilirubinaemia in jaundiced infants of different ethnic backgrounds. This study funded by the Children's Liver Disease Foundation will clarify logistical difficulties and the prevalence of benign jaundice in the third and fourth week after birth.

Professor Mowat and Dr Dick comment:

We are pleased to have Professor Matthew's support in trying to achieve surgical treatment for all infants with biliary atresia by 60 days of age. Because we share some of the concerns he expresses, we do not advocate screening for biliary atresia but selective screening or more correctly case finding by detecting conjugated hyperbilirubinaemia in jaundiced infants to detect all forms of hepatitis-biliary disorders. Mosaic will have other hepatitis-biliary disorders for which early and specific treatment is desirable. By screening at the same time as the infant is being assessed by community healthcare managers the cost and logistic difficulties will be minimised.

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Double blind placebo controlled trial of pizotifen syrup in the treatment of abdominal migraine

EDITOR,—Now and then the concept  'abdominal migraine' appears in the literature as if it were a fact. I have always been reluctant to accept it as a special entity. The only thing that distinguishes it from recurrent abdominal pain in Apley's definition is the exclusion of the milder cases. The demonstration of a special visual evoked response pattern in children with migraine and abdominal migraine is of course interesting.

But it is necessary to do this test in an unselected group of children with recurrent abdominal pain, to see if it delimits a special group among these children, or if it is a common phenomenon in children with recurrent abdominal pain. Even if it should delimit a special group it might just be a question of severity.

I am not able to refute the existence of abdominal migraine. But until now nothing except severity seems to justify the concept. Migraine in a close family member is a pre-requisite for the diagnosis of abdominal migraine. But not even this criterion seems to be of any help, as accumulation of several kinds of presumed psychosomatic symptoms including headache is very common in children with recurrent abdominal pain and in their families. I would still prefer the expression recurrent abdominal pain for all bellyachers, at least until we know more about aetiology and pathogenesis.

These reflections should be seen as a comment on the paper of Symon and Russell showing effect of pizotifen in children with abdominal migraine. It is of course important to show that pizotifen does work. But the information that this paper gives rise to two important questions. How does pizotifen work on all children with recurrent abdominal pain? And does the effect of pizotifen in a group of children with severe pain justify the migraine diagnosis?

Aetiology of recurrent abdominal pain is not certain, but it is likely that psychosomatic mechanisms are operative. In the complex pathogenesis different peptides and motility may be important factors. Is it in this context that the effect of pizotifen should be considered.

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Dr Symon and Dr Russell comment:

Recurrent abdominal pain is a symptom and not a diagnosis. We find no difficulty in accepting that children with recurrent headaches may be suffering from a wide variety of different diseases, including migraine, tension headaches, and even cerebral tumours. Similarly recurrent abdominal pain may be the final symptom of a wide variety of disease processes. In our practice the commonest cause of recurrent abdominal pain is constipation. The concept that all recurrent abdominal pain is psychosomatic in origin has been discredited by the absence of any statistically significant differences between children with recurrent abdominal pain and pain free children with regard to various psychological variables thought to be associated with psychogenicity.

The children whom we treated in our trial were not 'bellyachers' but were suffering from recurrent severe disabling symptoms. Unlike