Dr Kelnar comments

I am grateful to Professor Boyd for his comments on my annotation. I hope that I emphasized sufficiently that explanation and reassurance may be all that is required. A decision has to be made on clinical grounds as to whether that is the case — a situation frequently faced by paediatric endocrinologists and many general paediatricians.

I also discussed the poor quality of some previous studies and the need for more scientific information before definitive recommendations can be given. In that regard, studies are in progress in a number of centres and a further contribution from this department is soon to be published in this journal. Selective and appropriate hormone treatment is not designed to "narrow the range of normality" (nor will it do so) but to relieve distress. The extent to which it achieves that must also be assessed scientifically and such studies are also in progress in this department and elsewhere. Not all boys presenting with short stature and pubertal delay are 'future Professor Boys' and some are likely to be significantly socially and psychologically disadvantaged at a time which is critically important for determining future work or career prospects. Potential physical consequences of delayed puberty also require proper prospective evaluation.

I believe, with Professor Boyd, that 'explanation, empathy, and reassurance' are often enough. Where they are not, my view is that effective hormone treatments are now available and can reasonably be considered and prescribed on the basis of currently available scientific knowledge.


Dr Green and coauthors comment:

We agree that bowel ultrasonography has a place in the diagnosis of colonic strictures, however, we feel that it is an observer dependent investigation. While it is a valuable screening procedure, we do not think that it may not be the case with less experienced interpretation. In the child with recurrent and troublesome abdominal pain it would be unfortunate to miss the occasional intussusception in the case of strictures by not proceeding to contrast studies. We would therefore be reluctant to suggest relying entirely on a normal plain abdominal film and ultrasound as routine practice in every centre.

Management of anaphylactic reactions to food

EDITOR,—Patel et al draw attention to the use of food badges for children with potentially life threatening anaphylactic reactions.1 As a community paediatrician who has been responsible for the support of over 20 children with this problem over the last two years I must strongly disagree. They are often ignored, shaped by the parents of children with these badges being seen as a threat to "normal" life. A more practical approach would be to give mothers and fathers the skills to deal with anaphylaxis if it occurs. This could be taught at community paediatric clinics where there is opportunity to see many children. The importance of allergy education at school has also been highlighted.2

Abdominal pain is a very common symptom in patients with cystic fibrosis, but because of the recent concern about fibrotic strictures, radiological investigations into the cause of such pain are now being performed early. Our practice is to perform a plain abdominal radiograph and ultrasound of the bowel. If these investigations are normal, then there is little to be gained by proceeding to contrast studies.

children in a sensitive way. After all, we do not put a badge on the child with a learning problem saying 'I'm stupid, please give me extra teaching'. Surely we can apply the same principles and sensitivity to children with potential anaphylactic reactions.

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Ectodermal dysplasia and immunodeficiency

EDITOR,—Immunodeficiency has been previously described in patients with ectodermal dysplasia; surprisingly it was not mentioned at all in the recent review article on ectodermal dysplasia in this journal. Immunodeficiency is not a constant feature in all patients with ectodermal dysplasia, it is often transient and variable and no consistent T or B cell abnormality has been found. The exact nature of the association between these two rare conditions is unclear and the question remains as to whether different immune defects in patients with ectodermal dysplasia represent a coincidental association or whether immunodeficiency is an underrecognised feature of the ectodermal dysplasia syndrome. In two recent classifications of primary immunodeficiency disorders ectodermal dysplasia is listed under 'syndromes associated with immunodeficiency'.

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How to write a scientific paper

EDITOR,—I enjoyed Professor Lilleyman’s excellent article on how to write a scientific paper. Unfortunately he doesn’t mention the importance of acknowledgments and thanks. More and more papers it seems to me are based on other people’s data and are largely the results of postal surveys, with the authors merely analysing the data and writing the paper, but not seeing any patients or collecting any data themselves. I think it is even more important in these circumstances to acknowledge and thank those who have taken the trouble to reply to the questionnaires. This lack of courtesy might even be the reason why some surveys have an unsatisfactory response rate.

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