The same criteria for ductal closure—disappearance of murmur, return of pulses to normal, and resolution of heart failure—were used in both studies and correlated with the return of diastolic flow. Although the numbers are small, there was no apparent difference in the efficacy between bolus and slowly infused indomethacin.

Our findings are that bolus indomethacin resulted in a pronounced fall in blood flow velocity in the superior mesenteric artery. We believe this fall in velocity represents a local vasoconstriction. This view is supported by animal and human data[1-3] and the observation that the magnitude of fall in velocity was different in the two vessels studied.

The important messages, however, are that with a patent ductus arteriosus the splanchnic blood flow is compromised, and that slowly infused indomethacin avoids the profound fall in gut blood flow velocity that is seen with the first bolus dose of indomethacin.

1 Lippton HL, Armstead WM, Hyman AL, Kadowitz PJ. Characterization of the vasoconstrictor activity of indomethacin in the mesenteric vascular bed of the cat. *Prostaglandins Leukotrienes Med* 1987;27:81–91.
2 Feigen LP, King LW, Ray K, Beckett W, Kadowitz PJ. Differential effects of ibuprofen and indomethacin in the regional circulation of the dog. *J Pharmacol Exp Ther* 1981;219:679–84.
3 Eriksson S, Hagenfeldt L, Law D, Patrono C, Pinca E, Wennalm A. Effect of prostaglandin synthesis inhibitors on basal and carbon dioxide stimulated cerebral blood flow in man. *Acta Physiol Scand* 1983;117:203–11.

Modern management of pyloric stenosis—must it always be surgical?

SIR,—The paper by Eriksen and Anders[1] and the commentary[2] interested us because the management of pyloric stenosis has often provoked controversy. In 1986 we also audited 62 cases presenting between 1979–85 to a mixed paediatric medical and surgical ward outwith the specialist paediatric surgical unit. Preoperative fluid and electrolyte replacement was managed by paediatricians and operations were performed by general surgeons. Prophylactic antibiotics were not given routinely.

Complications in our infants compare favourably with those of the two other recent series (see table).[1 3]

Our audit emphasised the point made by all three contributors,[1-3] that the diagnosis of pyloric stenosis is not always straightforward. It also varies considerably in severity and so it was gratifying that Dr Jacoby's work[4] was quoted by Mr Kiely.[2] Although Jacoby operated on 104 babies with minimal morbidity and mortality there were a further 101 who tended to present later, have less severe vomiting, showed less weight loss and dehydration, and who responded rapidly and successfully to atropine methonitrate (Eumydrin).

In our series of 62 babies, seven were treated successfully with Eumydrin, had a very short hospital stay, and were treated predominantly as outpatients for a mean of seven weeks (range 2–16). In 1987 Eumydrin was taken off the market, having been in use for 60 years. Paediatricians were thus denied the opportunity of avoiding surgery with its 24–50% complication rate. We would like to report that the product Piptalin (Boehringer Mannheim), which contains the antispasmodic pipenzolate bromide, has been used successfully in three babies with pyloric stenosis in the past 12 months. Nowadays few junior staff have any experience of judicious medical treatment for pyloric stenosis. Babies are, therefore, referred without a second thought for surgery, which fortunately carries a negligible mortality, although the complications described above should not be ignored.

Should medical treatment for pyloric stenosis be totally abandoned?

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Complications of pyloric stenosis

	Zeidan et al[1] *(1980–5, n=106)*	*Eriksen and Anders (1984–9, n=46)*	*Present series (1979–85, n=55)*
Perforated duodenal mucosa	9	11	6
Wound infection or abscess	6	7	7
Persistent vomiting	9	2	3
Wound dehiscence	0	2	0
Incisional hernia	0	1	1
Haemorrhage	1	0	0
Need for second pyloromyotomy	0	0	1
Total No (%) complications	25 (24)	23 (50)	18 (33)

1 Eriksen CA, Anders CJ. Audit of results of operations for infantile pyloric stenosis in a district general hospital. *Arch Dis Child* 1991;66:130–2.
2 Kiely EM. Commentary. *Arch Dis Child* 1991; 66:132–3.
3 Zeidan B, Wyatt J, Mackersie A, Brereton RJ. Recent results of treatment of infantile pyloric stenosis. *Arch Dis Child* 1988;63:1060–4.
4 Jacoby NM. Pyloric stenosis: selective medical and surgical treatment. A survey of 16 years' experience. *Lancet* 1962;i:119–21.

Collodion babies with Gaucher's disease—a further case

SIR,—Lui *et al* reported two neonatal siblings with ichthyosis and Gaucher's disease who died in the first days of life.[1] We wish to report another case.

Case report

The first child of a non-consanguinous white couple was born at appropriate weight for gestational age at 32 weeks' gestation. There was no family history of birth defects, skin disorders, or haematological problems. At birth the baby had moderate ichthyosis with ectropion and some restriction of movement of the digits, presenting as a mild form of the 'collodion baby' phenotype. Hepatosplenomegaly was noted. The ichthyosis improved over the first 10 days, thrombocytopenia developed, and the baby's condition deteriorated with apnoea, suspected infection, and jaundice. Because of the report of Lui *et al*, leucocyte enzyme assays were performed and showed a gross deficiency in the β glucocerebrosidase activity measured with the natural β glucocerebroside substrate (53 pmol/min/mg protein, normal 600–3200) or the artificial 4mu substrate (19 pmol/min/mg protein, normal 60–220). The child died at the age of 3 weeks and postmortem liver histopathology confirmed a diagnosis of Gaucher's disease.

This is the third reported case in the same city in Australia. The family in Lui *et al* came from the western suburbs of Sydney.[1] The families were unrelated. We suspect that this diagnosis may be being overlooked in the differential diagnosis of ichthyosis in the neonatal period.

The reason for the association is by no means certain. Other associations with disorders of lipid metabolism and ichthyosis include X linked ichthyosis with steroid sulphatase deficiency, neutral lipid storage disease, Refsum's disease, and multiple sulphatase deficiency. Alternatively, it was suggested by Lui *et al*, the combination may represent manifestation of a contiguous gene disorder.[1]

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1 Lui K, Commens C, Choong R, Jaworski R. Collodion babies with Gaucher's disease. *Arch Dis Child* 1988;63:854–6.

BOOK REVIEWS

The Child Surveillance Handbook. By D M B Hall, P Hill, D Elliman. (Pp 257; £14·95 paperback.) Radcliffe Medical Press, 1990. ISBN 1-870905-66-0.

At last a readable book that paediatricians can recommend for general practitioners, health visitors, and community medical officers undertaking child health surveillance.

The book is divided into two parts 'health promotion', which is further subdivided into primary, secondary, and tertiary prevention, and 'putting the programme into practice' which is split by developmental stages up to school entry. The latter has a very basic 'what to do' and 'how to do it' approach to commonly encountered clinical problems that will suit those new to surveillance.

The child psychiatry input to the assessment and management of common behaviour problems is particularly valuable and will add greatly to the practical value of the book. The flow diagrams and diary suggestions should lead to successful resolution of many of these types of disorder.

No book of this size could claim to be comprehensive, and personally I would have liked a larger section on breast feeding and management of breast feeding related problems, the effects on children of separation and divorce,