Acute Gastroenteritis

Sir,—I would like to comment on three aspects of your very concise and topical leading article headed "Acute Gastroenteritis" (3 January, p. 70).

Although certain specific strains of *Escherichia coli* are undoubtedly concerned in the aetiology of gastroenteritis in young children, it is still possible that this disease is primarily a viral infection, and the recent finding that it is transmitted from person to person raises the possibility that a more fundamental reason for the epidemics in these outbreaks is the presence of a virus strain that is not yet recognized. This is based on the observation that young infants without any complication other than occasional transient haematuria. I have performed bladder puncture on 150 leucocyturia patients (4 ml. urine) and found bacterial growth of >10⁹ organisms/ml. in 18 and in each of these 18 there was bladder urine leucocyturia which could be immediately ascertained and was of invaluable help in management, especially in the outpatient clinic. All of the remaining specimens were sterile, and only a few of them contained leucocytes, in low numbers.

It is a very easy matter for the clinician to look for bladder leucocyturia in all of his patients, and if a "clean catch" urine cannot be obtained from those at "risk" then bladder puncture should be performed. This is a procedure that is relatively serious than venepuncture, which gives the clearest specimen and most cut-clear answer. Indeed, the clinician-microscopist usually has the satisfaction of telling the diagnosis on the spot. I am, etc.,

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REFERENCES

Diagnosis of Pylephritis in Children

Sir,—Your recent papers (23 December, pp. 697, 702, and 705) and leading article (23 December, p. 691) on this subject call for some comment. The authors emphasize that the correct diagnosis of pyelonephritis in small children requires patience and time of an order which I believe to be beyond the resources of most of our ordinary nursery services today, and it would be impossible to conduct an adequate follow-up clinic along the lines described. Happily, the answer is in the hands of the clinician, for he can enumerate leucocytes in clean void urine to tell when there may be inflammation of the urinary tract and undertake a search for possible bacterial evidence of an infective cause for this. It has never been satisfactorily shown that bacterial infection of the urinary tract in childhood occurs without leucocyturia, and it is therefore easy to screen all children in and out of hospital to select those at "risk" of having an infection to see if the diagnosis can be confirmed or, more usually, excluded. When leucocyturia is shown in more than one clean void specimen it may be possible to obtain a "clean catch" specimen by inducing reflex micturition, especially in young babies with a full bladder, and this should always be tried. If it fails then bladder puncture should be done. The procedure is easy and has been performed on hundreds of young infants without any complication other than occasional transient haematuria. I have performed bladder puncture on 150 leucocyturia patients (4 ml. urine) and found bacterial growth of >10⁹ organisms/ml. in 18 and in each of these 18 there was bladder urine leucocyturia which could be immediately ascertained and was of invaluable help in management, especially in the outpatient clinic. All of the remaining specimens were sterile, and only a few of them contained leucocytes, in low numbers.

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