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- 997 **Twice-Daily Therapy for Strep?** Ellis C. Gill, MD, Austin, Tex, Michael A. Gerber, MD, Farmington, Conn . . . **Falls From Pickup Trucks During Childhood** Timothy Tong, MD, Patricia A. Teaford, MD, Phoenix, Ariz. . . **Acute Suppurative Adenoiditis** COL Michael R. Weir, MC, USA, MAJ Newton O. Duncan, MC, USA, Tacoma, Wash . . . **Collagenous Colitis in a Child** Anthony Busuttill, MD, Edinburgh, Scotland . . . **Computed Tomography in the Diagnosis of Osteoid Osteoma in Infancy** Jesus Fleta, MD; Antonnio Sarria, MD, PhD; Gonzalo Oliván, MD; Manuel Bueno, MD, PhD; Maria Luisa Bello, MD; Tomás Castiella, MD, Zaragoza, Spain . . . **Clear Heads and Bayesian Tales: Predictive Value and the Coin Toss?** Robert D. Mauro, MD, Denver, Colo; Daniel S. Halperin, MD, Geneva, Switzerland; George W. Brown, MD, Los Lunas, NM . . . **Priapism Following Testosterone Therapy for Delayed Puberty** L. Lyndon Key, MD; Marybeth C. Myers, MD; R. Lawrence Kroovand, MD, Winston-Salem, NC; William S. Kelly, MD, Kernersville, NC

EDITORIALS

- 1006 **Why Wait for DTP-E-IPV?**
Edgar K. Marcuse, MD, MPH, Seattle, Wash
- 1007 **Poliovirus Vaccine Policy**
Samuel L. Katz, MD, Durham, NC
- 1013 **LEADS FROM THE MMWR**

THE EDITORIAL BOARD SPEAKS . . .

- 1020 **Computer Timidity: Some Thoughts**
Milton Arnold, MD, Los Angeles, Calif

ARTICLES

- 1021 **Computers in Medicine**
Eric G. Handler, MD, MPH, Madison, Wis
- 1024 **Cast Bronchitis in Infants and Children**
Agustin Pérez-Soler, MD, Barcelona, Spain
- 1030 **Purpuric Rashes in Cystic Fibrosis**
Daniel V. Schidlow, MD; Howard B. Panitch, MD; Nayere Zaeri, MD; Joseph Zenel, MD; Brad E. Alpert, MD, Philadelphia, Pa
- 1033 **Emergence of Isolates Resistant to Ampicillin**
David G. Rugar, MD; Margaret C. Fisher, MD; Hansel Fletcher, MS; Joel Mortensen, PhD, Philadelphia, Pa
- 1038 **Anti-Staphylococcus aureus IgE Antibodies for Diagnosis of Hyperimmunoglobulinemia E—Recurrent Infection Syndrome in Infancy**
Aubert Lavoie, MD; Menachem Rottem, MD; Marshall P. Grodofsky, MD; Steven D. Douglas, MD, Philadelphia, Pa



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Subepithelial deposition of collagen is known to occur also in the small bowel in the condition variously termed *refractory sprue* or *collagenous enteritis*,^{11,12} and, indeed, the nomenclature for this disorder was derived from the small-intestinal counterpart. Antigenic hypersensitivity to dietary proteins other than gluten has been suggested as a cause for small-bowel mucosal fibrosis: milk and soya proteins in infants; and tuna, egg, and chicken in adults¹² have been implicated. No such dietary association has been shown in collagenous colitis.

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1. Lindstrom CG. 'Collagenous colitis' with watery diarrhoea: a new entity? *Pathol Eur*. 1976; 11:87-89.

2. Giardiello FM, Bayless TM, Jessurun J, Hamilton SR, Yardley JH. Collagenous colitis: histologic and histopathologic studies in seven patients. *Ann Intern Med*. 1987;106:46-49.

3. Jessurun J, Yardley JH, Giardiello FM, Hamilton SR, Bayless TM. Chronic colitis with thickening of the subepithelial collagen layer (collagenous colitis): histopathologic findings in 15 patients. *Hum Pathol*. 1987;18:839-848.

4. Fausa O, Foerster A, Hovig T. Collagenous colitis: a clinical, histopathological and ultrastructural study. *Scand J Gastroenterol Suppl*. 1985; 107:8-23.

5. Palmer KR, Berr H, Wheeler PJ, et al. Collagenous colitis: a relapsing and remitting disease. *Gut*. 1986;27:578-580.

6. Wang KK, Ferrault J, Carpenter HA, Schroeder KW, Tremaine WJ. Collagenous colitis: a clinicopathologic correlation. *Mayo Clin Proc*. 1987; 62:665-671.

7. Weidner N, Smith J, Pattee B. Sulfasalazine in the treatment of collagenous colitis: case report and review of the literature. *Am J Med*. 1984;77:162-166.

8. Rams H, Rogers AI, Ghandur-Mnaymeh L. Collagenous colitis. *Am Intern Med*. 1987;106: 108-113.

9. Hwang WS, Kelly JK, Shaffer EA, Hershfield NB. Collagenous colitis: a disease of pericypt sheath? *J Pathol*. 1986;149:33-40.

10. Eriksen J, Fenger C, Meinicke J. Arthritis and collagenous colitis: report of a case with concomitant polyarthritis and collagenous colitis. *Scand J Rheumatol*. 1983;12:93-95.

11. Weinstein WM, Saunders DR, Tytgat GN, Rubin CE. Collagenous sprue: an unrecognized type of malabsorption. *N Engl J Med*. 1970; 283:1297-1301.

12. Baker AC, Rosenberg IH. Refractory sprue: recovery after removal of non-gluten proteins. *Ann Intern Med*. 1978;89:505-508.

Computed Tomography in the Diagnosis of Osteoid Osteoma in Infancy

Sir—Osteoid osteoma is a benign bone tumor that principally affects men in

the second decade of life. The clinical manifestations include a characteristic pain with nocturnal exacerbations that recedes or disappears after taking aspirin. In addition, muscular atrophy in the affected extremity and functional impairment are noted. If the tumor is located in the vertebrae, scoliosis can result. The most frequent locations are the femur, tibia, vertebrae, and humerus. A preliminary diagnosis can be made clinically, but confirmation is made by the visualization of the pathognomonic bone lesion, which is the "nidus" surrounded by an area of sclerosis. After surgical treatment, pathological study can confirm the diagnosis by examination of biopsy specimens.

We present a series of patients with osteoid osteoma in whom computed tomography assisted in diagnosis of the lesions.

Patient Reports.—Six children ranging in age from 3 years 5 months to 12 years 6 months were studied and included four boys and two girls with diverse localizations of osteoid osteoma. The clinical symptoms were manifested for a mean of 11 months and consisted of pain with nocturnal paroxysms that improved after administration of aspirin. One patient with osteoid osteoma in the spinal column had scoliosis. In those in whom the osteoma was located in the extremities, muscular atrophy and functional impairment were also observed. The roentgenographic study only identified the specific bone lesion in half of the patients, a characteristic nidus, as well as the perilesional sclerotic bone reaction. All of the patients were treated surgically. The postoperative course was satisfactory for all patients, and the diagnosis of osteoid osteoma was confirmed by pathologic examination.

Comment.—Although the diagnosis of osteoid osteoma can be suspected by the clinical signs and symptoms, it is not unusual that it takes months or years to confirm. The fact that the pain is exacerbated at night and improved with aspirin administration is suggestive of the diagnosis but not specific enough. Due to its rarity in children, it is frequent that the pediatrician does not think of this lesion, above all because the general state of the patient is good and fever or local inflammation is not usually present.¹

The traditional diagnostic test is roentgenography of the affected bone. In the majority of cases, a radiopaque lesion less than 2 cm in diameter is seen. Its form is oval or round, surrounded by a zone of bone condensation due to reactional hyperostosis.

In other patients, as with our series, a nidus is not visible; therefore computed tomography (CT) of the affected area is indicated.^{2,3} In all of our patients in whom CT was performed, it was possible to identify the nidus and measure its size, which permits differential diagnosis from osteoblastoma. On the other hand, CT also allows the visualization of bone condensation surrounding the nidus, as well as the local muscular atrophy produced by inactivity.

From our results, we conclude that CT is the preferential technique for the diagnosis of osteoid osteomas.

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1. Huguén P, Bensakel H. Réflexions à propos de l'osteoma osteoide chez l'enfant. *Chir Pediatr*. 1978;19:83-92.

2. Bello ML, Albareda A, Palanca A, Burillo B, Seral F. Osteoma osteoide de columna lumbar: estudio pre y postoperatorio con tomografía axial computarizada. *Rev Esp Cir Ost*. 1983;18:405-411.

3. Nelson OA, Greer RB. Localization of osteoma of the spine using computerized tomography: case report. *J Bone Joint Surg Am*. 1983;65:263-265.

Clear Heads and Bayesian Tales: Predictive Value and the Coin Toss?

Sir—Drs Halperin and Doyle, in their response to a recent letter,¹ made an assertion that deserves clarification. They stated that "... diagnosing ITP [idiopathic thrombocytopenic purpura] on the basis of a positive serologic test would be as accurate as flipping a coin," given a positive predictive value of approximately 50%. The statement is accurate in this context, since they were referring to data gathered on a population of patients' sera that had a prevalence of ITP of approximately 50%.² In general, however, using a coin flip as a screening test does not produce a *fixed* positive predictive value of 50%. Instead, it produces a positive predictive value