genetic test for XLH, while considering just what this sort of genetic testing can mean to affected families. Because of the network, we are much more confident in our children's treatment because it is obviously the approach of the best centres. Because of the network, we know more about osteotomies, Ilizarov apparatus, bone pinning,

stapling, and cajoling, so that while the trepidation is still there, we face our son's imminent tibial osteotomy with reasonable confidence too.

Managing a chronic condition successfully may involve every member of the family, since even the ones who aren't directly affected still feel deeply for their loved ones, and for their own

self-esteem and continued good health, they do need to be involved too.

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IMAGES IN PAEDIATRICS

"Fixed intestinal loop" on abdominal x ray: *sine qua non* of mechanical intestinal obstruction

A term neonate underwent primary closure of gastroschisis and limited small bowel resection for a perforation, in another institution. Four weeks later, gastric aspirates remained high and he developed abdominal distension. Contrast enema did not demonstrate any obstructive lesions. Plain abdominal x ray examinations on two subsequent days demonstrated a fixed, dilated intestinal loop (fig 1). At laparotomy, he was found to have extensive adhesions and complete occlusion of his previous anastomosis, with a dilated and atonic proximal segment. A limited resection with primary anastomosis was performed.

Persistent "ileus" obstruction following gastroschisis repair and a delay in commencing feeds for 20-30 days is common in gastroschisis babies.¹ The key is to distinguish between mechanical and functional subacute intestinal obstruction, as management will differ.

Radiological investigations play a vital role in the management of intestinal obstruction in all ages. Radiologically, the mid-small bowel is the most inaccessible and nondescript part of the gastrointestinal tract. Both mechanical and functional obstruction of the mid-small bowel can appear as non-specific dilatation on plain abdominal x ray. A fixed and dilated loop of bowel that does not alter in size, shape, and position on repeated abdominal films is highly suggestive of mechanical bowel obstruction due to an aperistaltic segment of bowel (usually due to ischaemia or gangrene). A typical example is in necrotising enterocolitis which mainly

Figure 1 "Fixed intestinal loop" (arrow) seen in two consecutive plain abdominal x rays taken 24 hours apart.

affects premature babies. It is a strong indication for surgical intervention and should not be overlooked.

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doi: 10.1136/adc.2003.037366

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