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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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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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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