

## LETTER TO THE EDITOR

### Re: Infantile Hypertrophic Pyloric Stenosis following Repair of H-type Tracheoesophageal Fistula Repair and Post-operative Erythromycin Therapy

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#### DEAR SIR

I have had a long term interest in the cause of pyloric stenosis (PS) of Infancy and read this paper with interest (Infantile hypertrophic pyloric stenosis following repair of H-type tracheoesophageal fistula repair and post-operative erythromycin therapy; published in 1st issue of volume 8, 2019).[1] I believe an inherited larger than normal Parietal cell mass explains all the clinical features.[2] Primary hyperacidity may also be considered as an explanation for the well-known increase in the incidence of PS in babies with TOF and EA. The alkaline amniotic fluid does not enter the stomach so these babies are born with un-neutralized gastric contents and have an acidity which is greater than normal. Acid induced repeated sphincter contraction follows with hypertrophy and PS, as the

natural result. In a sense it starts early and do not require to wait until the normal peak acidity at around 3 weeks of age.[2] Moreover, it is not necessary to invoke as the separate cause, as the authors do, stress release of growth hormones etc.

#### REFERENCES

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