on to state that 'testing for food allergy is an essential part of the management …' This is indeed misleading and would not only have horrendous cost implications but also not improve the care of most of our patients. General practitioners and dermatologists treat the majority of 'clinical' atopic eczema patients who respond well to standard treatment.

What about the rest of the world? An American study[7] concluded that '… at present, there is scant evidence that allergy is central to the development of atopic dermatitis, although it may be an aggravating factor in a few patients. Hence there is little rationale for the routine use of allergy testing … in the management of this disease.' The most recent guidelines, the Canadian Atopic Eczema Guidelines,[8] which use a clinical definition of atopic eczema, state: 'Some physicians send selected patients (i.e., those who fail to respond to standard therapy) for allergy testing to try to identify specific environmental or food allergies.' In a questionnaire-based study[9] investigators found that with effective topical treatment of atopic eczema 'Parental concern of food allergy decreased significantly from 7.7 to 4.0 on a 10 point scale ($P < .001$).' The latter is a helpful study to bear in mind when dealing with parents who insist on allergy testing.

Finally, the take-home message for the management of clinical atopic eczema at any age should be to aim for adequate topical care, referring poor responders to or discussing such cases with dermatologists who have a wide armamentarium that includes in-hospital care, ultraviolet light and systemic treatment. It is only in a few, mainly younger patients with unresponsive disease, that allergy testing and exclusion diets may be helpful. There is no agreement between dermatologists and allergy specialists on the definition of atopic eczema, as evidenced by the latest guidelines.[8] Interdisciplinary discussions and such an agreement would help to reduce confusion.

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P C Potter, A I Manjra, R Weiss, P du Plessis, N Rabobee, N Ndlova, M Davies and E Weinberg (Members of the SA Childhood Working Group of the Allergy Society of South Africa) reply: We welcome the opportunity to respond to Dr Khumalo's letter. We emphasise that these are guidelines for paediatric eczema. Not all cases of eczema are 'atopic', and the term 'intrinsic' or 'constitutional dermatitis' was applied to the subgroup that has no IgE elevation. Those with IgE elevation are in the 'atopic' eczema group. Eczema has always been understood as being atopic or non-atopic.

The new nomenclature guidelines[1] state that although atopy can be suggested by a family history, or certain physical features, e.g. Dennies lines, associated rhinitis or asthma, it can only be confirmed by the documentation of positive specific IgE tests to environmental allergens. Atopy is therefore defined as '… a personal or familial tendency to produce IgE antibodies in response to low dose of allergens, usually proteins and to develop typical symptoms such as asthma, rhinoconjunctivitis or eczema/dermatitis'.[1] The name 'atopic' implies that the patient is sensitised to allergens that can result in exacerbation of symptoms and should therefore be avoided.

Some patients with eczema have significant food allergy. Several studies[2] have proved that food allergens exacerbate symptoms in children with atopic dermatitis. Implications of distinguishing atopic from non-atopic eczema include prevention of adverse reactions to food, preventing asthma development, indications for probiotics, and the prevention of eczema flares. These interventions require specific confirmation of elevation specific IgE in children with eczema. In a large study[3] of infants with eczema, asthma prevention of more than 50% was possible in those children sensitive to house dust mites and grass pollen.

Dr Khumalo addresses the question of prevalence of IgE sensitisation in patients with eczema, quoting studies of Flohr *et al*.[4] The low rate of 7% that he quotes was derived from unvalidated questionnaire data from Kota Kinabala, Borneo, Malaysia, where the overall percentage of allergy present in the community was estimated to be only 4% in the non-atopic dermatitis group.

In June 2005 data were presented at the World Allergy Organization Congress in Munich from the EPAAC study (WAO-EAACI congress proceedings) on allergy prevalence in infants with eczema. In this study from Europe, Australia and South Africa, 60% of 2 184 infants aged 1 - 2 years with mild to moderate eczema (atopic dermatitis) had an elevated IgE. In the South African subgroup of 161 children, 47% were sensitised to egg, 28.4% to milk, 26.8% to peanut and 39.9% to house dust mites.

Dr Khumalo is incorrect in stating that testing for food allergy would have 'horrendous cost implications' as skin tests for the 5 common allergens can be performed for R75 in private

practice (and at less cost for state patients), less than the cost of a small tube of most topical corticosteroids. Our eczema guidelines recommend testing for 4 - 5 food allergens and possibly for house dust mites using skin tests. RAST tests are inexpensive if one restricts them to the 4 - 5 relevant allergens (egg, milk, peanut, soya, wheat, and house dust mites), based on a history of the patient's diet and geographical location.

The role of IgE Fcε receptor, mast cell, basophil and T-cell responses in the pathogenesis of eczema is complex and in some cases depends on environmental exposure. The role of IgE in non-atopic dermatitis, which mainly involves a TH-1 response, is less clear.

One cannot call all cases of this heterogeneous disease atopic dermatitis without even doing allergy diagnostic tests. In citing the paper by Flohr *et al*.[4] Dr Khumalo did not refer to their conclusion, namely that 'continued use of the term atopic dermatitis is problematic'.

Dr Khumalo concurs that those eczema children who are 'poor responders' have a chance of up to 69% of being allergic, but in his 'take-home message' suggests that they should receive hospital care, ultraviolet light and systemic treatment! This contradicts his previous statement, as the cost of such treatment would be very expensive, whereas exclusion diets are free. These recommendations should not be considered before food allergies have been excluded. Patients who do not respond to simple conventional topical treatments should receive a panel of inexpensive allergy skin tests or selected RAST testing. They would also benefit from an assessment by a practitioner with an interest in allergy.

Dr Khumalo is incorrect in asserting that there is 'no agreement between dermatologists and allergy specialists on the definition of atopic eczema' as dermatologists and allergists have embraced the new nomenclature worldwide. His statement reflects the sentiments of a few old-school practitioners who continue with the incorrect use of the term 'atopic dermatitis' in eczema patients who have no evidence of atopy! This should be called 'non-atopic eczema'.

Having recognised the importance of allergy in children with eczema it is likely that working relationships between dermatologists and allergy specialists will continue to strengthen.

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Minimal access or minimal invasive surgery

To the Editor: In an excellent paper at the 2005 Congress of the South African Society of Obstetricians and Gynaecologists, Dr E Rosemann stated that 'laparoscopy is the leading cause for legal action against gynaecologists in South Africa, and … it is a growing industry'.[1] In my opinion, and also that of others,[2] a major reason is that laparoscopic surgery has been industry-driven, with the consequence that major procedures have been performed without proper prior research or training.

A second reason is that the terms 'minimal access' and 'minimal invasive surgery' are both used to indicate that an operation is associated with minimal trauma, and therefore minimal risk of complications and early discharge from hospital. This concept is wrong and misleading, since minimal access does not necessarily imply that minimal invasive surgery will be performed. The term minimal access surgery means that small incisions are used to gain access to the abdomen or pelvis, usually for diagnostic laparoscopy or laparoscopic surgery. This term can also be used for mini-laparotomy. The term minimal invasive surgery means that a minor operative procedure has been performed inside the abdomen or pelvis, e.g. a partial salpingectomy for an early tubal pregnancy.

However, minimal access (or minimal entrance) can also be used for maximal invasive surgery, e.g. radical hysterectomy and lymphadenectomy for cervical cancer. This requires a highly trained and skilled laparoscopic surgeon, or the operation will be fraught with danger.

In conclusion, the terms minimal access and minimal invasive surgery are not synonymous. This implies that even where a minimal access route of entrance to the abdomen or pelvis is used, the degree of invasion of the surgery to be performed will determine the degree of surgical expertise required. The type of surgery should be based on the findings of well-designed prospective clinical trials. In the absence of such trials, the safest and most beneficial approach should be used. An example is early ovarian cancer, where the role of laparoscopy is undefined, and laparotomy is still the gold-standard surgical procedure for diagnosis and staging.[3]

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