that beta-blockers do not influence the six-week mortality in suspected myocardial infarction; that is why we refrained from drawing such a conclusion in the paper. We did, however, feel that as the outcome at one year was almost identical in the three groups our colleagues would be likely to conclude that the early administration of atenolol or propranolol would not influence the longer-term survival of their patients with suspected infarction.

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Ketotifen in adult asthma

SIR,—Your correspondence columns continue to contain letters about the new anti-asthmatic drug ketotifen. While it may be of interest to some doctors what other clinicians' individual experiences are in a few patients, it is hardly evidence of efficacy or safety of a new treatment in 1980—only a well-conducted, formal, double-blind controlled trial can provide this.

My concern, however, is when uncontrolled and unsubstantiated evidence is used to compare a new treatment with a well-established and safe treatment. I refer specifically to the last paragraph of Dr S G Spiro's letter (22 March, p 862), in which he claims a comparable incidence of side effects from ketotifen and inhaled sodium cromoglycate. It is not clear from the letter whether this evidence is based on the 413 subjects quoted or another series of trials—if so, which trials and in which patients, and what was the nature of the side effects?

Our own experience with trials of inhaled sodium cromoglycate is that, while a number of patients report transient coughing and throat irritation as a consequence of inhaling a dry powder, this can hardly be called a side effect that is likely to influence continuing treatment when therapeutic benefit occurs. If the 40% quoted by Dr Spiro includes a substantial number of "side effects" of this type, then I think that it is misleading to equate them with the drowsiness reported by ketotifen administration.

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* * * We sent a copy of this letter to Dr Spiro, whose reply is printed below.—Ed, *BMJ*.

SIR,—The data included in my letter (22 March, p 862) summarised the total number of side effects, both specific and non-specific, recorded from 413 patients taking ketotifen and 78 patients taking sodium cromoglycate in a series of 13 studies organised by Sandoz Limited. All these studies were controlled, against either placebo or sodium cromoglycate, and were blind. Dr Edwards is not justified in calling these data uncontrolled or unsubstantiated. It is, however, probable that many of the side effects volunteered by those taking sodium cromoglycate were of a non-specific nature not necessarily related to the drug, while the commonest side effect with ketotifen was drowsiness in 12.6% (52) patients, which was severe enough to withdraw the drug in 16.

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Sulphasalazine in rheumatoid arthritis

SIR,—Dr D W James and Dr Jane S Reeback criticised (22 March, p 861) Dr B McConkey and colleagues (16 February, p 422) for failure to submit either sulphasalazine or dapsone to a placebo-controlled trial in rheumatoid arthritis. I want to point out that a preliminary analysis of a double-blind trial comparing dapsone and placebo in rheumatoid arthritis was recently presented.¹ The trial demonstrated significant differences at 14 weeks between the groups with respect to clinical measurements and falls in acute phase reactants.

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¹ Swinson DR, Jackson L, Zlosnik J. *Abstracts of Ninth European Conference of Rheumatology*. Wiesbaden, 1979:51.

Growth and growth charts

SIR,—Dr H B Valman's series of articles "The first year of life" is a refreshing approach to our understanding the problems of the newborn baby and its first year of life. However, we would like to make some comments on his recent contribution relating to growth and the use of growth charts (9 February, p 381).

The first concerns the measurement of length. Dr Valman writes: "Length (or height) is difficult to measure accurately in a very young baby. . . ." Unfortunately this statement perpetuates the myth, widely held by doctors and nurses, that it is difficult to measure a baby's length. This is not so. With remarkably little training crown-heel length can be measured accurately with a length measurer (neonatometer) specially designed for the young infant.¹ Unfortunately many babies do not have length measured at birth. Some are inaccurately measured by a tape measure stretched from head to heel. Surely it is time to encourage the accurate measurement of length as part of the newborn examination. For too long has length at birth been neglected. It is as important a baseline measurement of growth as is weight and head circumference.

The second point relates to the use of growth charts giving an "early warning of obesity." Referring to one of his weight charts showing upward centile crossing, Dr Valman comments: "If the mother had been shown the growth chart at the age of 4 months she might have been able to have prevented the phenomenon seen at 6 months." It is not sufficiently realised that over the first year of life there is a considerable upward and downward centile crossing of distance weight curves as the infant leaves behind intrauterine influences on its growth and begins to follow its own genetically determined course. We have recently studied distance weight curves of 66 normal-term babies over the first year. Only eight (12%) kept approximately in the same channel in which they were born. Eighteen (28%) showed downward centile crossing. The majority (40—that is 60%) showed upward centile crossing. The greatest amount of weight shift took place in the first three months after birth—the time when mothers most commonly bring their babies to the health clinic for routine weighing and other health advice. We are uncertain about the significance of the high incidence of upward centile crossing. It is unlikely that all these babies were becoming obese. Instead we suspect that it

might in part reflect secular changes in patterns of weight gain.

The weight standards widely used in paediatrics are derived from cross-sectional analysis of weights at various ages² so that considerable caution must be exercised in evaluating an individual weight pattern against such standards, particularly at a time of shifting growth. A lot of anxiety can be caused by drawing too much attention to upward centile crossing. In recent years one of us (DPD) has seen many wholly breast-fed infants showing this weight pattern. Could these breast-feeding mothers have prevented this phenomenon? We believe not. In evaluating a pattern of weight gain it is always wise to ask about feeding. But if a baby seems to be sensibly fed no further action should be taken.

The use of growth charts is fundamental to monitoring health in infants and children. Clear guidance must be given to doctors and nurses as to how they should be used.

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¹ Davies DP, Holding RE. *Arch Dis Child* 1972;47: 938-40.

² Tanner JM, Whitehouse RH, Takaishi M. *Arch Dis Child* 1966;41:454-71.

SIR,—Dr H B Valman's remark on the inaccuracy of tape measures (9 February, p 381) prompts us to report on a study we made at the beginning of this year. The study confirms the dangers mentioned by Dr Valman but, contrary to what he says, we found linen tapes shrink—as do the glass fibre tapes which he recommended for head measurement.

We undertook a survey of all 47 tape measures used in this hospital. The tape measures were five-foot (152-cm) tapes of varying age and of two types: one was a woven linen tape and the other was a plastic tape sealed over a fibre-glass backing. Some of both types of tape were found to have shrunk up to 6.4 cm in length. The tapes were used to measure a 40-cm length on a steel tape (the 50th percentile head circumference of a 3-month-old girl).¹ Half the tapes measured this as over 41 cm. Twenty per cent of the tapes measured this as over 41.6 cm (the 90th centile head circumference of a 3-month-old child).

We found that the shrinking of all the tapes increased with the degree of wear or if they had been sterilised by soaking in 1% aqueous Hibitane (chlorhexidine), which was the method of tape sterilisation used in the neonatal and infant wards. To avoid this error we suggest that a new disposable tape, or a steel tape, should always be used for clinical measurement.

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¹ Gairdner D, Pearson J. *Arch Dis Child* 1971;46:783-7.

SIR,—Growth charts are an invaluable aid in following the progress of young children. It is most appropriate that Dr H B Valman should devote a whole article of his useful series to