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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

Effect of maternal diazepam on the newborn

SIR,—Diazepam seems to be the favourite sedative among obstetricians in the management of mild pre-eclamptic toxæmia according to the survey conducted by Mr G V P Chamberlain and his colleagues (11 March, p 626). May I point out what diazepam does to the newborn baby?

High doses (30 mg or more) of diazepam administered during labour cause, in the infant, failure to start breathing, shallow, inadequate respirations, periodic cessation of respiration, floppiness, subnormal temperature, and poor sucking.¹⁻³ These effects last several days and significant plasma levels of diazepam and of its active metabolites persist for up to eight days.¹ Diazepam accumulates in the tissues of the fetus,⁴ and is metabolised and excreted slowly by the newborn baby. It is therefore reasonable to assume that chronic administration of diazepam given in therapeutic doses could cause similar effects, and indeed there is some evidence that this is so.⁵⁻⁷ Symptoms from withdrawal of diazepam have been described in the newborn.⁸

The popular hypnotic nitrazepam is closely related to diazepam and could have similar effects.⁶ The depressant effects of pethidine and other drugs given during labour would be made worse by diazepam; such depression is not always obvious from the relatively crude Apgar score. Diazepam is excreted in breast milk,⁹ which may sedate the baby and cause feeding difficulty.¹⁰ Finally, there is the fear of impairing future intellectual development by exposing the developing brain to the influence of tranquillisers.

Obstetricians are already under attack for embracing new developments without proper

prospective trials.¹¹ How often must we be reminded of the ancient precept "primum non nocere"?

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² McCarthy, G T, O'Connell, B, and Robinson, A E, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1973, **80**, 349.

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⁴ Erkkola, R, Kanto, J, and Selman, R, *Acta Obstetrica et Gynecologica Scandinavica*, 1974, **53**, 135.

⁵ Gillberg, C, *Lancet*, 1977, **2**, 244.

⁶ Speight, A N P, *Lancet*, 1977, **2**, 878.

⁷ Kanto, J, Erkkola, R, and Selman, R, *Annals of Clinical Research*, 1973, **5**, 375.

⁸ Rementeria, J C, and Bhatt, K, *Journal of Pediatrics*, 1977, **90**, 123.

⁹ Ayd, F J, *International Drug Therapy News Letter*, 1973, **8**, 38.

¹⁰ Patrick, M J, Tillstone, W J, and Reavy, P, *Lancet*, 1972, **1**, 542.

¹¹ Chalmers, I, and Richards, M P M, in *Benefits and Hazards of the New Obstetrics*, ed M T Chard and M P M Richards, pp 34-61. London, Heinemann, 1977.

Reactions after pertussis vaccine

SIR,—Dr A H Griffith (1 April, p 809) has provided a comprehensive and careful review of adverse reactions associated with the use of Wellcome pertussis vaccine. He rightly draws attention to the possibility that variations in the vaccines made by different manufacturers may in some way affect the incidence of adverse reactions, but in considering this topic it is important that clear distinctions be drawn between fact and suppositions or

inferences. If this is not done there is a danger of confusing the medical profession still further about the complex technical problems surrounding the manufacture, testing, and use of pertussis vaccines. The differences in the vaccines discussed in the article relate mainly to *efficacy* and *toxicity*: several points call for comment.

(1) Dr Griffith makes the bald statement (p 810), reiterated with emphasis in your leading article in the same issue (p 806), that "Wellcome pertussis vaccine... has been found to be more protective than another manufacturer's vaccine." It so happens that the other vaccine was made by Glaxo; this is no secret, since the names of the manufacturers concerned were published in the report referred to.¹ It is, however, unfortunate to say the least that neither Dr Griffith's paper nor your leading article makes it clear that this report, although published in 1973, was entitled "Efficacy of Whooping Cough Vaccines Used in the United Kingdom before 1968" (my italics). In the 1971 addendum to the *British Pharmacopoeia* the minimum standard of potency was specified as 4 international units per dose; needless to say, all vaccines made in the United Kingdom have since then—if not indeed before—complied with this statutory requirement.

(2) There are implications (pp 810 and 812) that vaccines other than Wellcome do not necessarily contain agglutinin 3, which appears to be important for protection. Again, however, Dr Griffith refers only to papers dating from the 1960s that deal with vaccines made before the value of this antigen was widely recognised. It has for some time been the general practice to include it in pertussis vaccines; the Lister Institute has certainly done so for many years.

(3) Dr Griffith states (p 811) that pertussis vaccines are prepared "either dispersed in liquid medium in large tanks or on the surface of a solid medium containing charcoal" (the Wellcome method). Lister vaccine is prepared by neither of these techniques: the organisms are grown in suspension in 8-litre roller bottles. So far as comparative efficacy is concerned, it is worth mentioning that in the 1953-6 MRC trials a direct comparison was made of a solid-medium and two liquid-medium vaccines, all containing the same