non-crying babies. Hutt⁷ describes parallels. High pulse rates have been found in withdrawn psychotic patients.⁸

While preparing a paper on adolescent suicide attempts in this health district over 12 months I noted that, with a few exceptions, both the mothers' memory and medical records indicated that the 40 teenagers were non-crying babies. I had hoped to entitle the presentation "The unheard cry growing up."

Although, as Dunn surmises,² parents and babies are allowed time to adjust and early reactions are certainly not exclusively all-important for future emotional development, awareness of "silent" infant protest is important. We can then deal with causative factors and learn to contain also the anxiety or aggression arising therefrom.

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¹ Klaus M, Kennell J. *Maternal infant bonding*. St Louis: Mosby, 1976:74-81.

² Ciba Foundation Symposium 33. *Parent infant interaction*. Oxford: Association of Scientific Publishers, 1975:137-48, 155-68, 201, 241-60.

³ Ainsworth M, Bell SM. *Child Dev* 1972;43:1171-90.

⁴ Klaus M, Kennell J. *Maternal infant bonding*. St Louis: Mosby, 1976:38-97.

⁵ Dunn J. *Distress and comfort*. London: Fontana, 1977:90-7.

⁶ Sander L, Rexford E, Shapiro T. *Infant psychiatry*. Yale University Press, 1976:63.

⁷ Hutt S, Lenard H, Precht H. *Advances in child development and behaviour*. New York: Academic Press, 1969:127-67.

⁸ Venables P. *Research in psychophysiology*. London: Wiley, 1975:282

Common napkin rashes

SIR,—The most common napkin area eruption is an irritant frictional contact dermatitis primarily affecting the convexities and with groin sparing. It is correctly referred to as irritant napkin dermatitis but unfortunately is still sometimes called ammoniacal dermatitis, as Dr H B Valman does (21 June, p 1525).

Irritant napkin dermatitis, which is uncommon in the first month of life, may present as erythema, papulovesicles, or erosions. Certainly ammoniacal dermatitis occurs and is usually the erosive type of irritant dermatitis and one can smell the ammonia, but irritant dermatitis is usually not ammoniacal. Indeed, the affected skin and napkin pH is acid in some of these infants. It has been suggested that, in occasional cases, urinary ammonia may play a secondary role in aggravating already damaged skin but that by itself it does not initiate a dermatitis.¹

Regarding nappy liners, the popular fabric and paper ones increase the chance of frictional irritation and may cause a W-shaped dermatitis² but use of pure Terylene nappy liners is safe.³

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¹ Leyden JJ, Katz S, Stewart R, Kligman AM. *Arch Dermatol* 1977;113:1678-80.

² Larrègue M, Gallet P, Rat JP, Bressieux JM. *Dermatologica* 1975;151:104-12.

³ Verbov J. *Practitioner* 1978;220:779-84.

Sleep disturbance in the young child

SIR,—The review of sleep disturbance in the young child by Dr M C O Bax (10 May, p 1177) is a nice example of an excellent article by the wrong author. The subject is,

as he admits, one which concerns the whole family, so that however far the paediatrician moves into the community he will never be the appropriate professional involved. Nearly all of these problems are brought to the health visitor and the general practitioner, who will of necessity remain the experts in this field.

The only British papers in the very limited literature on the subject are from general practice^{1 2} and were not referred to. The text of the article, incidentally, did not refer to the first two references. But it was a pleasure to read such a thoughtful paper. Even Professor Court's committee might agree that, however essential paediatricians are in childhood illness, minor behavioural disturbances of infancy are the province of the present primary team.

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¹ Seiler ER. *Practitioner* 1972;208:271-6.

² Aylett MJ. *Update* 1977;14:367-72.

* * * We regret that the first two references were not cited in the text of Dr Bax's article. They should have been included in the first sentence of the second paragraph.—ED, *BMJ*.

Beta-blockers in the treatment of myocardial infarction

SIR,—In his recent letter (19 April, p 1088) Professor Geoffrey Rose, commenting on the study by Dr R G Wilcox and others (29 March, p 885), made the important point that confidence limits should be reported in any "negative" trial. We have calculated the approximate 90% confidence limits for 18 clinical trials of beta-blockers in myocardial infarction for which we could obtain the necessary data, including the study by Dr Wilcox and his colleagues. Our results are shown in the figure. Wherever possible total mortality has been used, but in some trials only cardiac mortality was available. It can be seen that 14 of the 18 encompass within their 90% confidence intervals a potential 50% reduction in mortality. However, all but two studies^{1 2} fail to exclude the possibility of

an increase in mortality on treatment, thus demonstrating their inadequate size.

For reasons of visual clarity, our statistical methods are approximate; but we would emphasise that more precise methods do not affect the pertinent issue. Further details concerning the methods and also the full list of references will gladly be supplied on request.

Presentation of information in this way should not only caution us (as Professor Rose points out) against premature dismissal of potentially useful agents, but also stimulate us to ask if certain groups of patients are responding to treatment while others are not.

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¹ Multicentre International Study. *Br Med J* 1975; iii:735-40.

² Snow PJD. *Lancet* 1965;ii:551-3.

Retroperitoneal fibrosis associated with atenolol

SIR,—The letter of Dr M J Gavin and others (17 May, p 1227) commenting on the report of retroperitoneal fibrosis in a person taking atenolol by Mr J N Johnson and Mr J B McFarland (22 March, p 864) itself deserves comment.

Firstly, an erythrocyte sedimentation rate (ESR) of 24 mm in one hour in November 1975 can scarcely be considered to be raised compared with a value of 106 mm in July 1979. Such a minor elevation would be appropriate, for example, to any minor infection. The reason for measuring the ESR is unfortunately not given, but presumably it was done at a time when the patient felt temporarily unwell, as with a minor infection. Marked elevation of the ESR is, of course, common in both drug-induced and idiopathic retroperitoneal fibrosis.¹

Secondly, it is said that two expert patholo-

Effect of beta-blockers on postinfarction mortality: difference in mortality rates (shown by thick vertical lines) with 90% confidence limits expressed as a percentage of observed control rate in 18 controlled trials. O=oxprenolol; P=propranolol; AI=alprenolol; At=atenolol; Pr=practolol.