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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

*Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by *et al*; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.*

Contraindications to immunisation

SIR,—Although I realise that there is nothing more likely to provoke tedious controversy than vaccination, I must take issue with Dr Sheila J Webb (21 June, p 1534) and come to Dr H B Valman's defence over the question of immunisation during the common cold (3 May, p 1138). Dr Webb would like us to postpone vaccination during colds and snuffles, and this policy is widely carried out in child health clinics. As a result thousands of children fail to complete or even start their

vaccination schedule, and in my experience this is one of the most important reasons for failure of the immunisation programme in urban areas, where many babies and young children have snuffles almost all the year round. Their mothers simply get tired of being turned away.

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Crying and non-crying babies

SIR,—Dr H B Valman has presented an excellent synopsis on crying babies and methods of coping (21 June, p 1522). In general he mentions factors such as hunger, thirst, and lack of physical holding as important, together with fatigue, failures of mother-infant bonding, and after the age of 3 months loneliness. However, his introductory sentence, "Apart from the subtle method of eye communication a baby has no other way of signalling his needs to his mother than by crying," does not complete the picture. Studies have indicated how a baby can communicate messages to his mother by means of microscopic rhythms involving movement, smell, touch, other auditory methods, and

possibly an increased pulse rate and other psychophysiological reactions as well as facial expressions.¹

Certainly the handling of the crying baby is extremely important for the future well-being of the baby. The studies on crying by Dunn² and Ainsworth³ describe the importance of the maternal response and Klaus⁴ and others have shown how early mother-baby contact (in the first hour) assists in mother-baby bonding and decrease of crying. The importance of cultural and genetic factors regarding the amount of crying is also vital to bear in mind.⁵

Emphasis should also be laid on the importance of "non-crying" in babies who

later reveal emotional and adjustment problems. A recent pilot study carried out locally revealed interestingly that, of 100 children (4-17 years old) referred to the East Cornwall child psychiatry service, about half were described by their mothers as "non-crying" as babies—this half tending to present with behaviour disorders or the rare childhood psychotic disorders, while those described by the mothers as having cried as babies presented later with neurotic states, phobias, etc, in the main. The majority of the medical records corroborated mothers' recollection. A case was described, for example, where the mother had been "very emotional" during pregnancy and the postpartum period and was eventually treated for depression. The baby throughout was described as "contented." Feeding or sleep problems and being "very active" or "playing instead of sleeping" were mentioned by mothers of the non-crying group.

Extreme withdrawal and "false independence" may indicate great adjustment problems. Papoušek and Brazelton⁶ both show how early a baby can "shut off" and withdraw. This state may appear somewhat similar to sleep but a differentiating factor may be its sudden onset.

Slow onset of crying after removal of a pacifier, as Bell shows,² leads to a more "aggressive approach to life." Crying is but one of the ways a baby may signal experience of stress. Sander⁶ found high pulse rates in

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.