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CORRESPONDENCE

Management of acute illness in infants

SIR,—I share with Dr A N Stanton and others (29 March, p 897) concern over the diagnosis of serious illness in infants. Any attempt to define a group at greater risk than the mass of babies with non-specific illness is valuable. However, I fear that their conclusions, based on an uncontrolled retrospective survey, may be rather simplistic.

Their "major symptoms," of course, become important in any child who is subsequently ill enough to be admitted to hospital. What is not considered is the frequency of these symptoms in infants who make an uncomplicated recovery. I cannot remember seeing an acutely ill baby recently who has not had at least one of the symptoms of fever, cough, diarrhoea, vomiting, missed feeds, drowsiness, and irritability.

The question of what factors lead to referral to hospital is a complex and under-researched one. It is seldom as simple as "physical signs," "symptoms alone," "parents unable to cope," or "parental pressure." What is needed is a clear set of guidelines to the circumstances under which it is safest to disregard signs, symptoms, or any parental pressure, and admit immediately.

The effect on the family of an admission that turns out to be unnecessary should not be overlooked. Any child who has been admitted with an acute illness as an infant is likely to develop subsequent acute illnesses with apparently indistinguishable features. Previous needless admission reduces the confidence of the parents and their capacity to deal with trivial illness in the safest place—the home.

The message must be to visit soon and visit again. This paper may persuade me to admit more readily to hospital. That may solve some of the problems of the paediatrician; I do not believe that it necessarily solves all those of the general practitioner, or his infant patient.

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Systematic review of the benzodiazepines

SIR,—The "guidelines" issued by the Committee on the Review of Medicines (29 March, p 910) on the use of benzodiazepines will be read and reread by practitioners with interest, particularly since the possible dangers of these drugs are currently receiving brisk attention from television and the lay press.

There is much in the guidelines that busy doctors will find of value. However, some statements may prove to be perplexing. One of the more worrying is as follows: "It is ... suggested that ... prescriptions be limited to short-term use" (p 911). What is the clinician to make of this? Of course, we should all give our patients the shortest course possible of any drug, but what are the alternatives for symptomatic relief of chronic anxiety, tension, and insomnia? It would be a sad day if we returned to the older generation of sedatives and hypnotics. It is generally accepted that alternative drugs, such as barbiturates, paraldehyde, chloral, meprobamate, glutethimide, methyprylone, methaqualone, and ethchlorvynol, are more likely to produce physical dependence than the benzodiazepines[1 2] and that they are mostly far more toxic in overdose.

What relief can we then provide for the severe distress suffered by our patients? It would be unrealistic to think that the average medical practitioner has enough time, even if he had the inclination, to spend hours trying to identify and sort out the underlying problems in psychotherapy and counselling, and in any case many of the causes remain obscure even when this is tried. There is a clear danger that patients who are not offered any relief by the medical profession will turn to the solace of alcohol. There can be no serious doubt that the potential dangers of alcohol are far more sinister than those of the benzodiazepines.

There are problems ahead for general practitioners, physicians, and psychiatrists if the prescription of benzodiazepines is indeed "limited to short-term use," much as this is desirable in an ideal world.

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[1] Priest RG. *Insanity: a study of major psychiatric disorders*. Plymouth: Macdonald and Evans, 1977.
[2] Priest RG. In: Gaind RN, Hudson BL, eds. *Current Themes in Psychiatry*, No 1. London: Macmillan, ch. 8.

SIR,—I was sorry to read (29 March, p 910) that the Committee on the Review of Medicines regards children's nightmares and sleep walking to be an indication for the use of Benzodiazepines. May we know the evidence for this recommendation? As children commonly have nightmares or sleepwalking at intervals for years, are these drugs to be given continuously through childhood?

Sometimes these symptoms, when frequent, can be traced to insecurity arising from friction between child and parent. Would it not be better to counsel the family than to drug the child?

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Chlormethiazole and temazepam

SIR,—Professor I Oswald and Dr K Adam (22 March, p 860) criticised our paper (1 March, p 601) on several grounds. They were concerned that "an element of sleep deprivation" may have confounded a 30-minute