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SUPPLEMENT

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CORRESPONDENCE

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.

Whooping cough in the United Kingdom 1977-8

SIR,—In your issue of 29 March (p 945) Minerva offers the following comment: "The whooping-cough epidemic that began in 1977 and continued into 1978 was the biggest since 1957, with 65 957 notifications and 12 deaths. The Office of Population Censuses and Surveys attributes the change to the decline in vaccination. Perhaps those who claimed the vaccine is useless would like to comment."

Being prominent among those few who have questioned the efficacy and safety of pertussis vaccine,[1] I felt not just that I would like to comment but that I had a duty to do so. You will recall that I wrote to you and, shortly afterwards, submitted an article reporting my findings during the period in question. Unfortunately, you have rejected this paper; so, very reluctantly, I find myself unable to respond to the Goddess's invocation, timely and provocative as it was. The best I can do for the moment is to apologise to her for being seemingly unprintable and offer you in this letter the factual conclusions of my article, as follows:

(1) Estimates based on notifications indicate that there was in the 1977-9 triennium the largest outbreak of whooping cough in the UK for 20 years or more.

(2) During this period isolates of respiratory viruses ran in parallel and collectively outnumbered isolates of *Bordetella pertussis*.

(3) There was a highly significant positive correlation over the period between serial isolates of *B pertussis*, *Mycoplasma pneumoniae*, and echoviruses.

(4) Deaths of children with whooping cough were lower than in all previous outbreaks. Only a minority of these cases were bacteriologically confirmed.

(5) In Glasgow notifications were significantly higher in deprived areas. Only 18% of practitioners notified any cases and 2% notified 37% of cases. Notifications at peak did not correlate significantly with isolates of *B pertussis* but there was a significantly higher proportion of notifications in unvaccinated children aged 1-4 years. This was confirmed in family studies of clinical whooping cough in home contacts. About 35% of reported cases were children who had received three doses of pertussis vaccine. Acceptance of vaccine fell to about 50% in 1975 but about 95% of unvaccinated children in the age group 0-5 years, including the 1975 and 1976 birth cohorts, either escaped infection or were not notified as having whooping cough.

Conclusions without supporting data are no better and perhaps worse than the reliability of the person who offers them. I hasten to add therefore that my raw and processed data are available for inspection until such time as they may be published elsewhere.

Your referees are rightly critical about the use of notification data and other official returns. But so am I. The main lesson of the paper is that epidemiological surveillance of childhood infections is so inadequate as to be a danger rather than a safeguard at present.

You will perhaps forgive me if I remind you that this is the fourth time that you have rejected an article by me on whooping cough, though I am happy to acknowledge that you have never rejected any one of several articles by me on other subjects since 1950. I am not on this account questioning your editorial