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Dr Taylor comments:

I am most grateful to Drs Grange and Stanford for drawing my attention to the apparent association between reduced natural infection with *M bovis* in milk and the increased incidence of childhood leukaemia. The UK Childhood Cancer Study (UKCCS) is currently collecting information about episodes of infection and histories of immunisation in children with leukaemia and in matched controls. It should be possible to obtain preliminary indications from these data about any protective effect of BCG vaccination. The idea that therapeutic immunostimulation using BCG could be used to treat childhood leukaemia is not new. However, the results of the MRC's Concord trial in childhood acute lymphoblastic leukaemia¹ and more recent studies failed to indicate any significant benefit of BCG immunotherapy. In adult myeloid leukaemia combined BCG/allogeneic immunotherapy stimulated strong cell mediated immunity to donor, but not to autologous leukaemia cells,² and produced little long term benefit. The use and expense of prophylactic BCG vaccination as an immunological protective measure in childhood leukaemia would only be justified if it markedly reduced the incidence of the disease. Positive preliminary evidence from the UKCCS might justify a detailed case-control study of this question in the UK. However, bearing in mind Greaves' hypothesis that childhood leukaemia could arise from inappropriate immunostimulation,³ there is much to commend a cautious and considered approach to the use of prophylactic BCG vaccination as a preventative measure in childhood leukaemia.

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- 3 Greaves MF, Alexander FE. An infectious etiology for common acute lymphoblastic leukemia in childhood? *Leukemia* 1993; 7: 349-60.

Cough - but is it asthma?

EDITOR.—Dr Sheila McKenzie has suggested that cough without wheeze should not be classified as asthma unless there is evidence of airway lability.¹ In practice, chronic persistent cough is most troublesome in preschool children who cannot reliably perform standard tests of lung function.

A study of 60 children under 6 years with chronic cough showed that 63% produced at least one positive reaction to skin testing with inhaled allergens (57% for house dust mite) compared with 75% of children with classical asthma and 10% of children without respiratory problems.² Chronic cough, like wheeze, was usually worse at night (75%), precipitated by exercise (85%), and associated with nasal discharge (70%) or sore throat (32%).

Two years after presentation 83% of children reported improvement or no cough

at all but 25% developed recurrent wheeze as well as cough. It was difficult to assess response of cough to treatment because of the tendency to spontaneous resolution.

Cough alone may just be a feature of the viral upper respiratory infection which can also induce wheeze in asthmatic children or it may be a manifestation of airway inflammation triggered by hypersensitivity to inhaled allergens such as house dust mite. Although most children with chronic cough do not have asthma, there is no reliable way of identifying those who eventually develop definite bronchospasm. For persistent cough a trial of inhaled β agonists or inhaled steroids is logical and potentially less harmful than other common remedies such as antihistamines, antibiotics, or even surgical ear, nose, and throat procedures.

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Growth standards for infancy

EDITOR.—We fully endorse the views of Wright *et al* on the need to develop new growth standards for infancy.¹ The comparison of their Newcastle data with widely used standards² and with the Cambridge Infant Growth Study³ illustrates this need succinctly. The Cambridge study is not, however, confined to breast fed infants. Although a high proportion (90%) were initially breast fed,³ this declined to 65% by 12 weeks, 54% by 24 weeks, and 18% by 1 year. Throughout most of the first year, the weights of infants breast fed to at least 24 weeks were similar to those bottle fed from 3 weeks. Both groups showed an increased weight gain compared with standards in the first six months, followed by a more marked relative decline, with only the breast fed boys showing a slightly slower growth after nine months compared with those bottle fed. At 1 year, the mean (SD) weights were: boys breast fed (n=54) 9.79 (0.93) kg, bottle fed (n=35) 9.93 (0.97) kg, girls breast fed (n=59) 9.17 (0.85) kg, bottle fed (n=24) 9.18 (0.80) kg, and the Z scores² were -0.4, -0.2, -0.5, and -0.6 respectively. Weaning practices are at least as important as mode of milk feeding. Energy intakes during and after weaning are lower now compared to the 1950s when the standards were prepared.⁴ In view of the differences in feeding practices and social circumstances, it is encouraging to find that the growth of Cambridge infants showed such similarities to the Newcastle data.

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- 3 Whitehead RG, Paul AA, Cole TJ. Diet and the growth of healthy infants. *Journal of Human Nutrition and Dietetics* 1989; 2: 73-84.
- 4 Paul AA, Whitehead RG, Black AE. Energy intakes and growth from two months to three years in initially breast-fed children. *Journal of Human Nutrition and Dietetics* 1990; 3: 79-92.

BOOK REVIEWS

Psychological Treatment in Disease and Illness. Edited by Matthew Hodes and Stirling Moorey. (Pp 230; £15 paperback.) Gaskell and the Society for Psychosomatic Research, 1993. ISBN 0-902241-57-5.

Any book which, in the opening few sentences, can give a name check to Hippocrates, Descartes and Freud, is clearly not going to come last in the erudition stakes. Of more importance is whether it can perform equally well - or better - in the areas of elucidation and education.

Happily for the reader, the answer is a resounding yes. This book addresses, both clearly and highly informatively, major developments in the psychological treatments of psychosomatic and physical disorders.

The stimulus for this book was provided by a conference entitled 'Psychological Treatment in Human Disease and Illness' which was held in 1990. Expansion and updating of original talks enable the editors to proclaim the text as 'state of the art'. Of additional benefit is that the book is coherent and authentic as a whole and does not suffer the disconnectedness of some texts derived from conferences rather than *de novo*.

The book is divided into two sections. In the first, there is an overview of psychoanalytic, cognitive behavioural, and family psychotherapy approaches in dealing with psychosomatic and physical disorders. The second section looks at the application of psychotherapeutic approaches to particular conditions such as somatisation disorder, irritable bowel syndrome, chronic pain, brittle diabetes, and anorexia nervosa.

The major strengths of the book are its clear description of both theory and practice, and its ability to bring the two together harmoniously.

Theoretically, there are good outlines of the ideas behind the different therapeutic approaches. Particularly strong is Tom Sensky's description of cognitive therapy, succinctly covering the important aspects of the cognitive model (including dysfunctional beliefs, negative automatic thoughts, and cognitive distortions), and its therapeutic approaches. He makes the important point that especially in physical illness, not all false beliefs are dysfunctional and not all dysfunctional beliefs are false. For example, denying the seriousness of illness or even its presence can sometimes serve as a protective function and is therefore not necessarily dysfunctional. Conversely, the belief of 'not having long enough to live to achieve what I want' might be true but might also be dysfunctional if it results in the ill person focusing on nothing other than this belief and giving up trying to achieve anything. Dr Sensky stresses that the focus of therapeutic work in cognitive therapy is to focus on dysfunctional beliefs, *not* to