Immunization Schedules

SIR,—The memorandum on routine immunization against infectious diseases (September 16, p. 763) is a shocking exhibition of ministerial inhumanity. Needle-pricks are an occupational hazard of being a baby, and should be cut to a minimum. The memorandum could be discussing injecting a cheese, not a live, sentient human being. There is no mention of infantile reactions to large needles repeatedly being thrust into him, of terrifying white coats, or of an antiseptic atmosphere of pain linked in the child's mind with clinics.

There is an excellent psychological reason why small-pox vaccination should be done at 10–12 weeks, and that a fortnight later first triple antigen (diphtheria–pertussis–tetanus) should be given and repeated at monthly intervals until completed at 6 months. It is that if these injections are delayed further the child becomes aware of why he is at the clinic or surgery, and receives a profound and lasting impression of pain associated with white coats and doctors, and which may upset him for years, even for life. I know that, fortunately, not all children are like this: but a great many are. Indeed, this impression may be the greater in the child's mind if the clinic has a poor psychological approach, where the doctor faces the baby with a syringe poised, and the babies or children are possibly in a queue in line. My own practice is never to let the baby see the needle. The baby is prone over the mother's knee, and the latter keeps one arm over his back and one over his legs, firmly. I use a needle made to my own specification which is a quarter of an inch (6.4 mm.) long and of 17 gauge. This can be inserted into the buttock rapidly, safely, and painlessly. To face a baby armed with a needle, to nip the skin of his left arm, and slowly to stick the needle in to the required depth is mediaeval torture. The method I use is effective enough, for I have never had a case of diphtheria or tetanus since the beginning of triple antigens, and very little, mild, whooping-cough, in vaccinated children. I think the Schedules P and Q are academic. Poliomyelitis vaccination has to be done later, from 7 months.

Perhaps the authors of the memorandum have never heard of Gesell, but his book is worth quoting[1]:

"At 4 weeks the neonatal period is drawing to a close. With each succeeding week the infant moves more deeply into his domestic environment. At 16 weeks he is already graduating from the cosy confines of his bassinet. He has longer and better defined waking periods; he may even demand social attention by fussing. His traits of individuality are becoming more obvious. Conflicts with excessive and untimely environmental pressures arise. His acculturation is well under way."

It is our business as doctors not to condition the child to hate us.—I am, etc.,

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[1] Gesell, A., *The First Five Years of Life*, 1940, p. 20. Methuen, London.

Sensory Loss in Poliomyelitis

SIR,—The interesting and important observation of Dr. R. V. Walley (July 1, p. 33) prompts me to add some of our own experiences in regard to this unusual finding. We have been working with poliomyelitis since 1952 and fully agree with Dr. Walley that "pains in the back and leg muscles are the rule, and loss or even alteration of sensation is extremely rare."

Since 1952–61 more than 1,600 polio cases have passed through the ward. Among them we came across two cases of hypaesthesia, one of them with complete sensory loss. In the latter a wide area of sensory loss was evident on the abdomen, back, and hips, with no response to marked painful stimuli such as pinching or pricking. Our consultant neurologist could find no explanation for this other than the underlying disease of polio. The unequivocal clinical diagnosis of polio (a flaccid paralysis of the lower legs, general adynamia, head drop) was confirmed by the finding of virus of polio type I in the stool and a rising complement-fixation titre in the blood.

Indeed, sensory loss in poliomyelitis is an unusual feature in the symptomatology. As we know, the usual sensory change in polio is hyperaesthesia, which, according to Mueller,[1] is an "early pathognomonic symptom." In the discussion on the clinical picture of poliomyelitis at the First International Poliomyelitis Conference, Ritchie Russell[2] states that he was impressed by the fact, which was emphasized by St. Thieffry, that the occurrence of poliomyelitis without pain is "quite exceptional." In a series of 100 described cases only two had no pain. Though the absence of pain is a rare feature, the presence of sensory loss is definitely an exceptional phenomenon.

It becomes more evident all the time, in our opinion, that poliomyelitis is not a monolithic disease as it seemed for a long time and as it has been stated in the textbooks for many years, but a most varied one, very often "bizarre,"[3] "*déroutante*,"[4] or even "erratic and unpredictable."[5] Serious authors, amongst them Weinstein,[6] do not consider the disease confined strictly to the nervous system, and think that it is rather a *diffuse* one which embraces in its clinical features other systems such as the vascular, the myocardium, the lymph nodes, the gastrointestinal tract, and others. We have drawn attention to some unusual features of the complex picture of poliomyelitis in Israel as observed in the last years.[7,8] It is not surprising therefore that we are often tempted by the popular cliché that "the more we learn about poliomyelitis the less we know about it."—I am, etc.,

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[2] Ritchie Russell, W., in *Poliomyelitis, Papers and Discussions Presented at the First International Poliomyelitis Conference*, 1949. J. B. Lippincott Company, Philadelphia.
[3] Horstmann, D. M., *Amer. J. Med.*, 1949, **6**, 592.
[4] Thieffry, S., Martin, Ch., and Arthuis, M., *Sem. Hôp. Paris*, 1959, **18**, 1349.
[5] Coriell, L. L., *Amer. J. Dis. Child.*, 1958, **95**, 349.
[6] Weinstein, L., *Circulation*, 1957, **15**, 735.
[7] Rotem, Y., *Harefuah*, 1959, **56**, 79.
[8] —— *Israel med. J.*, in press.

Medical Aid to Developing Countries

SIR,—How very well, and how very warmly, Dr. Bruno Gans (September 16, p. 767) has stated his views. As he so rightly asserts, there is an imbalance in medical and nurse training. Surely there is a wrong emphasis also in the mode and place of training of medical graduates and nurses from overseas. Many of them come for training, but especially in obstetrics and general surgery they remain to do a job. They remain to obtain experience not open to them overseas. Young overseas graduates exert their most enthusiastic efforts