ABC of 1 to 7 (Revised)

H B VALMAN

SLEEP PROBLEMS

Some children will not sleep when they are put to bed, but the most distressing problem for parents is those who keep waking in the night or wake in the early morning. The mother rapidly becomes exhausted, and marital discord may follow while the child remains fresh. Sleep problems are common. Twenty per cent of infants wake early or in the night at the age of 2, and it is still a problem in 10% at 4½. Between these ages the symptoms resolve in some children but appear for the first time in others. Drugs may cause irritability and sleep problems—for instance, theophylline preparations for bronchial asthma or phenobarbitone for febrile convulsions.

Normal patterns

During the first few weeks of life some babies sleep almost continuously for the 24 hours whereas others sleep for only about 12 hours. This pattern of needing little sleep may persist so that by the age of 1 year an infant may wake regularly at 2 am and remain awake for two hours or more. As these infants approach the age of 3 they tend to wake at 6 am and then remain awake for the rest of the day. Many 2-year-old children sleep for an hour or two in the afternoons, and some have a similar amount of sleep in the mornings as well. A child who spends four hours of the day sleeping may spend four hours of the night awake. Parents often worry that an infant is suffering from lack of sleep and wrongly ascribe his poor appetite or frequent colds to this cause.

During the night babies and children often wake up, open their eyes, lift their heads, and move their limbs. If they are not touched most of them fall back to sleep again. A mother who wakes as a result of this moving, gets out of bed, and looks at her child may keep him awake. If this happens several times every night it may prevent the infant from developing normal patterns of sleep.

History

The doctor needs to take a full history. He needs details of the sleep pattern, when the problem began, and measures taken to resolve it. It should be possible to determine whether the child has always needed little sleep or whether he has developed a habit of crying in order to get into his parents' comfortable bed. He should also explore the reason why the mother has sought advice at this stage. She should be asked about any change in the house, where the child sleeps, whether he attends a playgroup, and who looks after him during the day. Illnesses in the child or family and marital and social backgrounds also need considering. A physical examination usually shows no abnormality, but occasionally there may be signs of acute otitis media.

Difficulty in going to sleep

Harry was a white dog with black spots who liked everything, except... having a bath. So one day when he heard the water running in the tub, he took the scrubbing brush...

Difficulty in getting to sleep can often be avoided by starting a bedtime ritual in infancy. A warm bath followed by being wrapped in particular blankets may later be replaced by the mother or father reading from a book or singing nursery rhymes before the light is turned out. Some children have been frightened by a nightmare and fear going to sleep in case it is repeated. A small night light or a light on the landing showing through the open door may allay this fear. A soft cuddly toy of any type can lie next to the infant from shortly after birth, and seeing this familiar toy again may help to induce sleep.

The mother should be told that during the night babies often open their eyes and move their limbs and heads. She should be asked to resist getting up to see the baby as the noise of getting out of bed may wake him and he may then remain awake. If he does wake he may be pacified with a drink and may then fall asleep. His drink is to provide comfort rather than to assuage any thirst.

Parents whose young children sleep a great deal during the day can discourage them from doing this by taking them out shopping or giving them other diversions, and they may then sleep well at night.

Sleep disturbance is a common reaction to the trauma of admission to hospital or moving house, and taking the child into the parent's room for a few weeks may help to reassure the child that he has not been abandoned. If there are toys or other things to amuse them some children who wake in the night will play for hours, talking to themselves and not crying. Parents need to be reassured that this is perfectly normal and that they are lucky that the child does not demand their attention.

If the child is prepared to go to sleep at a certain time but the parents would like to advance it by an hour they can put him to bed five minutes earlier each night until the planned bedtime is achieved.

Behaviour modification and drugs

[illegible]

When the child wakes frequently during the night and cries persistently until he is taken into his parents' bed a plan of action is needed. If there is an obvious cause, such as acute illness, recent admission to hospital, or a new baby, the problem may resolve itself within a few weeks, and at first there need be no change in management. If there is no obvious cause the parents are asked to keep a record of the child's sleep pattern for two weeks (see sleep history chart). This helps to determine where the main problem lies and can be used as a comparison with treatment.

Both parents are seen at the next visit; both need to accept that they must be firm and follow the plan exactly. Behaviour modification is the only method that produces long-term improvement, but it can be combined with drugs initially if the mother is at breaking point.

Behaviour modification separates the mother from the child gradually or abruptly, depending on the parents' and doctor's philosophy. The slow method starts with the mother giving a drink and staying with the child for decreasing lengths of time. In the next stage no drink is given. Then she speaks to the child through the closed door and, finally, does not go to him at all. The abrupt method consists of letting the child cry it out; he stops after three or four nights. There are an infinite number of variations between these extremes, and the

Day	Time to bed	Time to sleep	First problem	What did you do ?	Second problem	What did you do ?	Time woke up in morning
Mon							
Tue							
Wed							
Thur							
Fri							
Sat							
Sun							

Number of minutes to wait before going into your child briefly

Day	At first episode	If your child is still crying		
		Second episode	Third episode	Subsequent episodes
1	5	10	15	15
2	10	15	20	20
3	15	20	25	25
4	20	25	30	30
5	25	30	35	35

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temperament of the parents, child, and doctor will determine what is acceptable.

Another approach is to increase the waiting time before going to the child. In severe cases a written programme of several small changes can be given to the mother and she can be seen again by the health visitor or family doctor after each step has been achieved. The mother will need to be reassured that the child will not develop a hernia from crying or vomit or choke, and neighbours may be pacified by being told that the child will soon be cured.

Many sleep problems can be resolved without drugs, but some mothers are so exhausted by loss of sleep that they cannot manage a programme of behaviour modification unless the infant receives some preliminary sedation. The most satisfactory drug in this age group is trimeprazine tartrate, 3 mg/kg body weight given one hour before going to bed. These large doses are needed as lower, more conventional doses are usually ineffective. The full dose is given for two weeks, followed by a half dose for a week; the drug is then given on alternate nights for a week. The objective is to change the pattern of sleeping. A behaviour modification plan is needed during the third and subsequent weeks.

Children around the age of 2 who wake early in the morning may be helped by giving them a low divan bed instead of a cot. They can get out of bed and play with their toys on the floor and leave the rest of the household to sleep.

MATERIA NON MEDICA

Fairy Father Brown

Rereading the Father Brown stories for the umpteenth time, I was struck by the remembrance that 1986 marks the fiftieth anniversary of the death of his creator. I have not heard of any commemoration of the event; a recent radio portrait of Chesterton on the BBC World Service failed to mention it. Being myself very young at the time I do not recall Chesterton's death, unlike that of his alter ego Hilaire Belloc who died in July 1953. I find to my surprise on consulting works of reference that other literary figures who died in 1936 were A E Housman and Rudyard Kipling.

There were giants in those days, literary giants. Chesterton and Belloc, Shaw, and Wells did not retire to remote areas of England or sunny southern Europe but were familiar public figures who engaged in fierce political debates. What was common to all was a dislike and mistrust of capitalism, although they had differing opinions as to what should replace it.

It is something like 50 years since the appearance of the first Penguin paperbacks. Those earliest publications are collectors' items to treasure. I am happy to see, however, that the recent Penguin *Complete Father Brown* contains the same brief but distinctive biographical note of Chesterton that I have always remembered and admired.

It is by his Father Brown stories that Chesterton is best known today. As with Sherlock Holmes, and unlike other detectives in fiction, his powers of deduction and analysis were taken from a character in real life well known to the author. Father Brown does not usually work with the police. He often induces criminals to repent; where they are beyond redemption they are likely to die by their own hand. Sometimes what appears to be a crime has resulted from the best of intentions. Sometimes Father Brown reconstructs and solves a crime years after the event.

Chesterton was a notable literary critic. Each Everyman's Library volume of Dickens includes his introduction to the work. His own favourite among the novels—if novels they were—was *Pickwick Papers*. He referred to

Mr Pickwick himself as the Fairy Pickwick, one who is immortal and tries to right wrongs. Seventy five years after his first appearance, it is no exaggeration to talk of the Fairy Father Brown.—R M SYKES, consultant paediatrician, Benin City, Nigeria.

A 5 year old boy has suffered frequent recurrences of localised urticaria ever since a booster dose of diphtheria and tetanus vaccine 18 months previously. The urticaria is localised to the injection site, lasts about half an hour, and appears more frequently when warm or before mild respiratory infections. What is the reason and what treatment, if any, is advised?

I have not been able to find any record of such a reaction, neither have several dermatological colleagues any experience of it, or indeed the manufacturers, Wellcome Foundation Ltd. In view of the localisation of the lesion it is reasonable to relate it to sensitivity to the previous injection of diphtheria and tetanus toxoids and accompanying compounds, such as preservatives. One could then surmise that occasionally similar preservatives may be ingested in food and trigger sensitised mast cells. Such types of urticaria usually last several hours, however, whereas it is the physical urticarias that usually resolve within the hour. Perhaps scratching may provide the trigger. Salicylates can exacerbate chronic urticarias but these could hardly be taken before mild respiratory infections. Can anyone help the "expert"? No treatment is indicated and his immunisation course against diphtheria is already complete. Nevertheless, immunity to tetanus toxin may need to be further boosted, especially after certain injuries. The preparation least likely to cause further reaction in these instances would be Tetanus Vaccine BP (in simple solution) 0.1 ml intradermally. This should only be given where appropriate resuscitative measures can be given.—GLYN WILLIAMS, consultant physician, Ayrshire.