eral pediatricians, I found that this method was unknown to several senior pediatric residents, a pediatric chief resident, and experienced private practitioners.

This method of removing nasal foreign bodies is not mentioned in several recent pediatric ear, nose, and throat (ENT) textbooks. Further search of the literature revealed that this technique has been mentioned by Stool and McConnel,1 who call it a "somewhat unesthetic technique that is safe, often successful and that does not require any instrumentation."

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REFERENCE

Pertussis Vaccine and Neurologic Disease

To the Editor.— The revised recommendations of the Committee on Infectious Diseases concerning the use of pertussis vaccine in infants with proven or suspected neurologic disease1 warrant comment. Such modified recommendations are needed because of confusion about the causation of coincident or preexisting neurologic disease that appears or is first recognized in temporal association with the administration of diphtheria, tetanus, pertussis, (DTP), which confusion has resulted in extensive litigation over alleged personal injury. Although most authorities believe that pertussis vaccine does on rare occasions produce permanent neurologic damage, it is clear that the vast majority of these alleged injuries are of other etiology.

But we believe that the approach offered by the Committee is not optimum. The Committee has recommended giving diphtheria, tetanus (DT) starting at age 2 months and deferring pertussis vaccine for a later decision in children with existing or suspected neurologic disease. In effect, the decision about the administration of pertussis vaccine can be made after the child's neurologic status has been clarified.

However, it is likely that such children will eventually need pertussis vaccine even if a neurologic problem becomes evident as time passes, in order to provide protection against pertussis in custodial and other group situations. Similarly, if the child turns out not to have a neurologic disorder, pertussis vaccine is indicated. Either way, it is likely that the status of the child will be reasonably clear sometime in the latter half of the first year of life.

We believe that a simpler approach than that suggested by the Committee on Infectious Diseases would be to postpone DT as well as pertussis vaccine. By 1 year of age, it ought to be possible to make a decision as to whether to immunize a child with DT or DTP. This plan is simpler logistically and more economical because it does not necessitate the procurement of monovalent pertussis vaccine. Moreover, since most of the current personal injury litigation over pertussis vaccine derives from simple coincidence and not causation, there is no reason to believe that the same confusion will not continue in regard to the diphtheria or tetanus component. Deferring diphtheria and tetanus immunization as well as pertussis up to 1 year of age would not seem to be irresponsible given the facts that most children less than 1 year of age are unlikely to incur tetanus-prone injuries and that there were only six cases of diphtheria reported in the United States in 1983.

Deferring DTP entails some risk of the child being not fully immunized due to losses to follow-up, and the physician who considers this course should evaluate the likelihood of compliance with subsequent visits. However, because children with existing or suspected neurologic disorders require regular medical surveillance, follow-up should not be a major problem.

Obviously, physicians should continue to observe the Committee's recommendation that further doses of pertussis vaccine be withheld from infants and children who have experienced one or another of the reactions to DTP that are specified in the 1982 Red Book.

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Breast-Feeding and Hyperbilirubinemia in Full-Term Newborn Infants

To the Editor.— Osborn et al1 have reported a positive association between breast-feeding and neonatal hyperbilirubinemia in full-term infants. To give further support to the findings of Osborn et al, we wish to report the results of two similar studies that have been completed in two different hospitals.

The first study was carried out in the nursery of the Second School of Medicine of Naples.2 Rooming-in was practiced from 9 AM to 12 PM, and during the day, breast-fed babies were only offered a supplement of 5% dextrose in water when appropriate. For a period of 6 weeks, one or two meals of an adapted formula were routinely given to all infants (n = 340) overnight. For a second period of 6 weeks, the formula was replaced by 5% dextrose in water (n = 405). All other routines remained unchanged during the study period (12 weeks). The two groups of infants were comparable for father's profession, maternal

LETTERS TO THE EDITOR 617
age, type of delivery, Apgar score at five minutes, sex, birth weight, and maximum weight loss during the first week of life (approximately 7% of birth weight in both groups). The frequency of hyperbilirubinemia (≥12 mg/dL) was 21.2% in infants supplemented with an adapted formula and 30.6% in those supplemented with 5% dextrose in water (P < .005). Seventeen percent of the infants in the first group and 25% of those in the second group had to be treated with phototherapy (P < .025). The frequency of breast-feeding at discharge from the hospital was similar in both groups (81% and 84%, respectively, P > .05).

The second study was performed in the nursery of the School of Medicine of Sassari. In this nursery, rooming-in was not practiced and the infants were taken to their mothers six times a day for feeding. Two groups of infants were studied during two 4-week periods: one group was supplemented with an adapted formula (120 infants) and one group was supplemented with 5% dextrose in water (117 infants). Here again the two groups were comparable for social class of parents, maternal age, type of delivery, Apgar score, sex, and birth weight. However, maximum weight loss was slightly but significantly (P < .001) greater in infants given supplements of glucose (dextrose) (7.3% of birth weight v 6.2%).

The frequency of hyperbilirubinemia (≥12 mg/dL) was higher in the second group (23% v 15%), although the difference did not reach statistical significance. On the other hand, phototherapy was required more frequently in infants supplemented with 5% dextrose in water than in those supplemented with formula (21.3% v 7.5% P < .005).

The frequency of breast-feeding at discharge was similar in both groups (84% v 93%; P > .05).

In both studies, there were no cases of hemolytic jaundice and serum bilirubin levels never exceeded 20 mg/dL. The results of our two studies, performed in two different institutions, with different nursery routines, are in good agreement with the data of Osborn et al. The mechanism responsible for the increased frequency of jaundice in infants supplemented with 5% dextrose in water remains unknown. The association between increased weight loss and hyperbilirubinemia in our second study suggests that caloric deprivation may play a role. However, differences in the enterohepatic circulation of bilirubin with the two feeding routines could also have occurred. In any case, the increase in serum bilirubin levels in infants fed dextrose and water, although statistically significant, is quite small and of modest clinical significance and does not justify the routine use of an artificial formula in breast-fed infants during the first week of life.

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