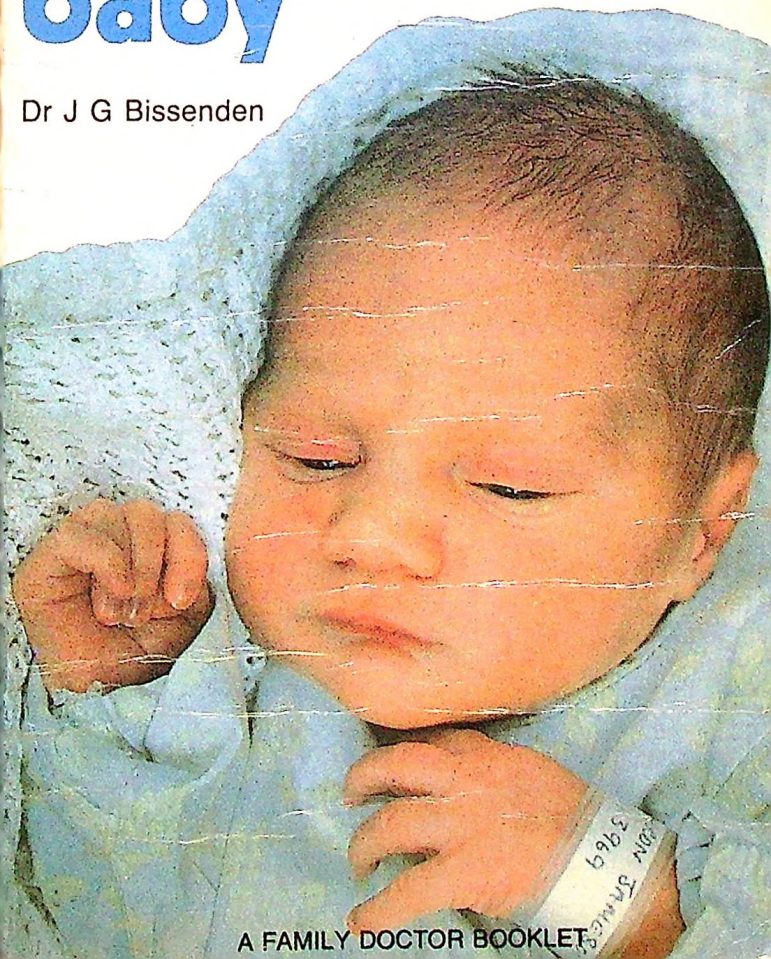
A BRITISH MEDICAL ASSOCIATION PUBLICATION

Your new baby

Dr J G Bissenden



A FAMILY DOCTOR BOOKLET

Your New Baby

Dr J G Bissenden

JAICO PUBLISHING HOUSE
Bombay ● Delhi ● Bangalore
Hyderabad ● Calcutta ● Madras

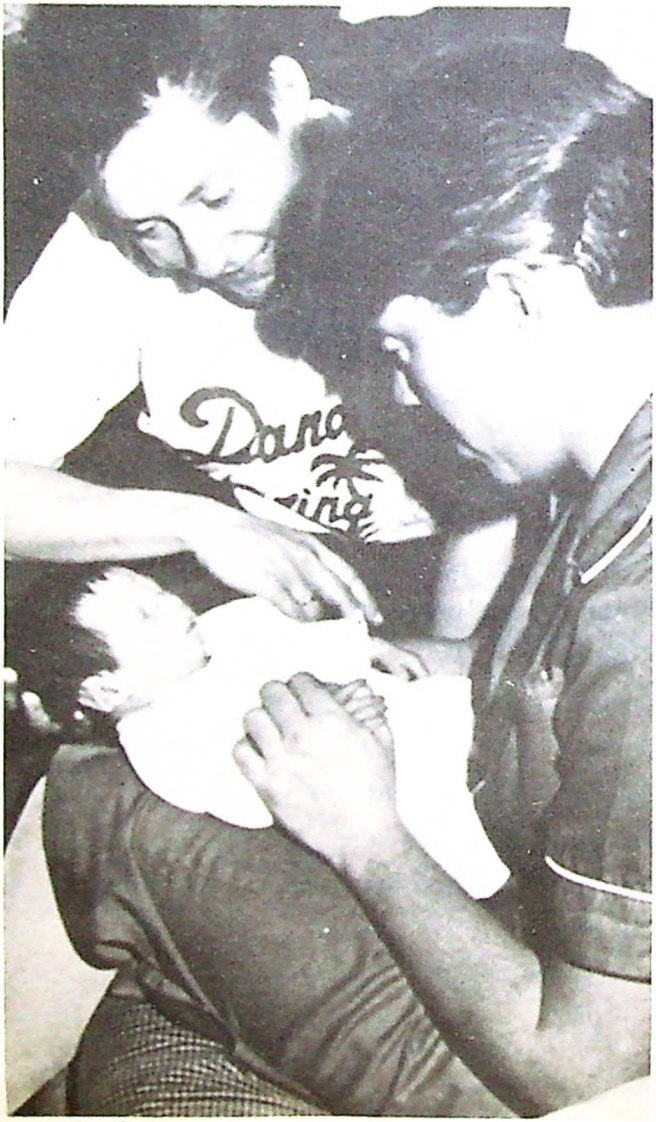
This is a Family Doctor booklet published in arrangement with the British Medical Association, BMA House, Tavistock Square, London WC1H 9JR.

YOUR NEW BABY

First Jaico Impression: 1990

Published by
Ashwin J. Shah
Jaico Publishing House
121, M.G. Road
Bombay 400 02

Contents



Introduction

Newborn babies are wonderful, and at the same time terrifying. Mothers can feel quite overwhelmed by the responsibility of looking after such a tiny, fragile looking creature, and although a baby can be the best thing that ever happened to a family, there may be times when even the most doting of parents would like to drop their precious offspring out of the window.

This booklet aims to help you through the first months. It gives you some guidelines to which you should adhere and will, I hope, reassure you about any worries you may have. But do remember that babies do not always follow set patterns, so don't panic and think that you are doing everything wrong if your baby insists on behaving differently.

Where to get help

The following people are there to help you look after your baby:

- District midwife: she will visit daily for 14 days after your baby's birth and can be an invaluable support for the new mother;
- Health visitor: she takes over from the midwife and provides information and help on child care, in the home and in the clinic;

- Child health clinic: the clinic doctor and health visitor advise on any problems, will check your baby's weight and growth, undertake developmental and screening examinations, and will usually carry out the immunisation programme;

- Family doctor: he or she could be consulted if you think your baby is ill. Some GPs undertake screening and immunisation;

- Hospital casualty department: you can take your baby to the casualty department in emergencies;

- Hospital paediatrician: these doctors specialise in the care of children, but you must be referred by your family doctor or the casualty doctor.

But don't ask everyone

If you are worried about something don't ask too many people for advice—you are almost certain to get a wide selection of different answers that will only confuse you further. If in doubt, consult your health visitor; she has a fund of training and experience to call upon and can usually be relied on to give sound advice.

It is impossible to cover everything in a booklet of this size so I have confined myself to the most important aspects of looking after a new baby and those problems which are common and cause greatest concern. I hope that mothers will forgive me if I refer to the baby as "he". This is for simplicity and does not reflect any preferences or bias on my part.

Is he all right?

One of the first questions that most parents ask after the birth of their baby is, "Is he all right?" And happily he usually is. Immediately after birth infants are examined for any abnormalities such as "bits missing" or "extra bits" and for any evidence of problems caused by the actual process of being born (birth trauma). The baby is always given a score out of 10 for his condition one minute and five minutes after birth. This "Apgar" score is based on his colour, heart rate, breathing etc.

Clinical examination

Later—often on the morning after delivery—the baby is given a thorough clinical examination. He is checked again for any missing or extra bits; the doctor listens to his heart, measures his head circumference, looks at the fontanelles (the two holes in a baby's skull), and assesses the baby's alertness; the genitalia and skin are examined; the eyes are looked at carefully in case of cataracts; and the baby's hips are tested to see if they are dislocated.

Dislocated hips

Dislocated hips are probably the most important abnormalities to detect as early treatment is simple and generally effective. The hip test is not very satisfactory but there is nothing better at present. For every

baby with a true dislocated hip that is detected and treated (with a splint) we find 20 with "wobbly" or "clicky" hips (which are probably harmless) and have to ask the parents to bring the baby back for a repeat examination. This may seem very annoying for parents but hips are so important that it is better to be safe than sorry.

All's well

If all is well the doctor may not have time to discuss the routine screening examination with you and will not mention odd marks like a red blemish between the eyes or bluish marks on the buttocks of Afro-Caribbean or Asian babies (see p. 36). These are normal birthmarks that fade in time. Even so if you notice something that you are not happy about do mention it to the midwife.

Blood tests

On about the 7th day of a baby's life, and provided he is feeding well, the midwife will take blood from his heel. This blood goes to a laboratory where it is tested to see that the baby's thyroid gland is working properly. The laboratory does another test (Guthrie test) on the same sample of blood to rule out an extremely unusual condition called phenylketonurea. Babies with this rare disorder need a special diet to remain of normal intelligence.

Sickle cell disease

In some parts of the country Afro-Caribbean babies are tested for sickle cell anaemia, so called because the red blood cells look like sickles under the microscope. This is a serious condition causing severe anaemia.

Both the parents of a baby with sickle cell anaemia "carry" the disorder in their genes but do not have the disease. If they have a further child there is a 25% chance that he will be anaemic, a 25% chance that he will be normal, and a 50% probability that, like his parents, he will be a healthy "carrier" of the condition.

The baby in special care

Every hospital that delivers large numbers of babies has a special care baby unit. The medical term for a newborn baby is a "neonate" so the ward may also be called a neonatal unit. Perhaps 10 out of every 100 babies born will have to spend some time in a special care baby unit. Most of these babies are premature or very small: they are not necessarily ill but their bodies are not well enough developed to feed, keep warm, or cope with the normal air and many need added oxygen.

Intensive care units

If babies are ill because they are very premature or perhaps because they got into difficulty during delivery, they may need intensive care. These babies are always in incubators and will be monitored by a bewildering array of equipment that checks their condition. Unfortunately, the equipment makes a lot of noise and it is very difficult for parents to relax. The doctor and the nurses understand this and will do everything possible to leave you alone with your baby.

If his condition is up and down, as it often is in the first few days, it may seem that every time you visit he is surrounded by people. Do remember that he is *your* baby and not the hospital's. If neither the doctor nor the nurses seem anxious to explain how he is and what is going on, stand your ground firmly and ask them what is happening. Occasionally the medical and nursing staff need reminding that in their anxiety to do the very best for the baby they have forgotten to explain everything to the worried parents.

Things are more relaxed now

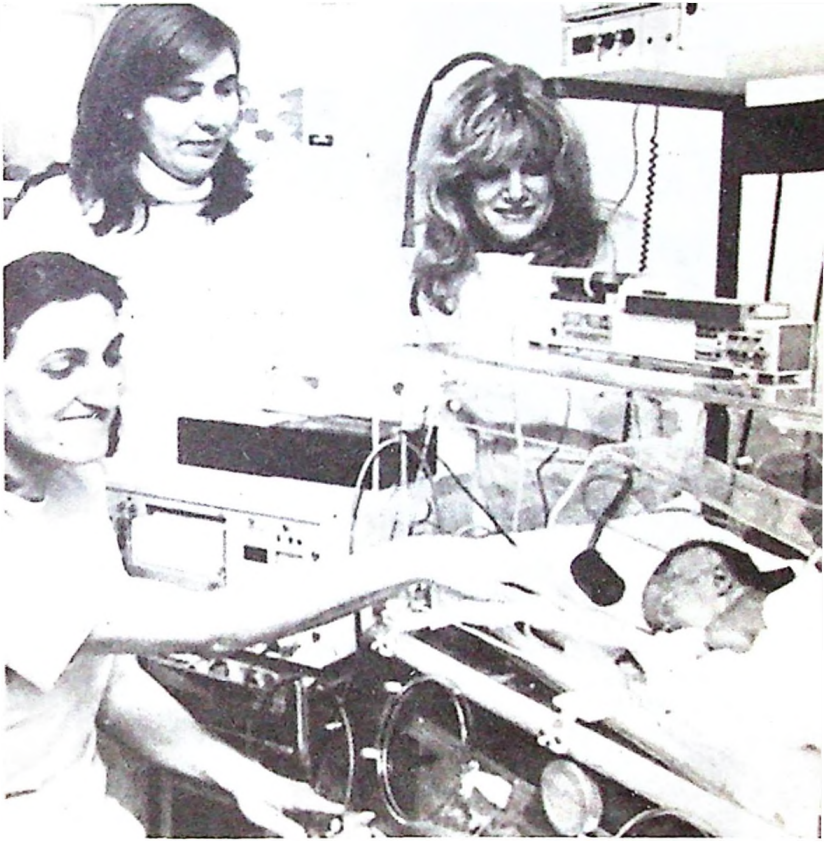
There was a time when parents were separated from their babies or could only view them through windows. I can remember explaining a baby's condition to his parents through a little window just like the one between the cashier in a bank and the customer! How times have changed. Most units have free visiting for any member of the family, though usually only two at a time. Hats and coats must be left outside but only a thorough wash of the hands is needed and parents don't have to wear special clothing. If you are not well, though, don't visit: it's not fair on your little one, or perhaps on the other babies.

Feeding a baby in special care

Your baby will probably need to be fed by a tube passed through his nose into his stomach (naso-gastric tube), and if very small, he may even be fed through a tube into a vein. He may be given dextrose at first but when he is well enough to have milk down the tube there is a choice. The mother can express her milk using a pump and equipment provided by the midwives or the baby can have a cow's milk based infant formula. Many doctors feel that, at least for the first few feeds, mother's own milk has great benefits. At these difficult times, it can be a mother's positive contribution when everybody else seems to be caring for her baby. It may also lead her on to establish successful breastfeeding.

Going home

Sadly, some babies are just too small and poorly to survive, and for one reason or another about 4 or 5 in every 1000 die. For most parents, however, there are the joys of looking forward to their baby coming home. It seems to take a frustratingly long time for him to grow and take all his feeds without a tube. Make sure you feel confident about handling your baby and try to



live-in for 24 hours before he comes home. The nurses on the baby unit may underplay how much your baby cries because they are not so emotionally involved. Remember too that babies are spoilt in hospital—they are fed often by their full-time "nannies".

The hospital will probably have a policy that babies are fed as often as they want, "demand fed", or at least four hourly so the baby coming home from special care expects his feeds promptly and will let you know all about it if he is hungry. With luck he will have slept in a darkened nursery away from the bustle of the special care unit before coming home. If not, he may not appreciate soft lights and quietness in his new abode.

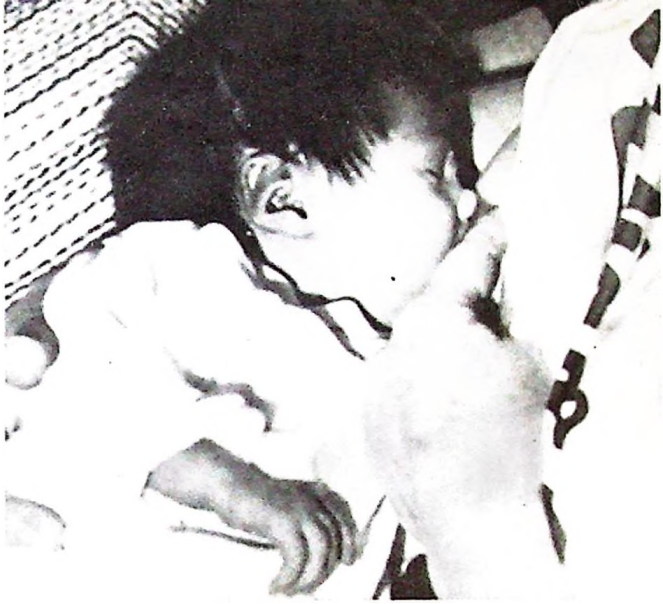
Feeding your baby

By the time you read this booklet you will have decided how you are going to feed your baby—and I hope you will breastfeed. If this is your second baby you will be influenced by what happened with the first. If breastfeeding went well, it almost certainly will again; if it was not a great success, you may have mixed feelings. Why not try again, if only for a couple of weeks? You can always change from breast to bottle but it is rather difficult the other way round!

Breast is best . . . but

On balance, doctors and midwives will always say breast is best. Years ago, when the alternatives to breast milk were less satisfactory, one could be dogmatic about this but now all the manufacturers of formula milks have modified the basic cow's milk to make it as close to human breast milk as possible. These formula milks are all as good as each other and to the baby there is no advantage or disadvantage in using Cow and Gate Premium, SMA Gold Cap, Aptamil, or Osterfeed. There is no question about the amount of nutrition they provide and babies will grow just as well on infant formula as on breast milk.

Although one could write forever on the advantages of breastfeeding, this is not the purpose of this booklet. I will, however, list the points in favour (and against) breastfeeding and bottlefeeding.



Breastfeeding

Advantages

- Breast milk is the perfect food for your baby;
- Breastfeeding is natural, convenient, and breast milk is "free";
- Breast milk offers some protection against allergies and against infections such as gastroenteritis in the early months;
- Breastfeeding may help mothers to lose any excess weight they gained during pregnancy;
- Breastfeeding can be emotionally rewarding;

Disadvantages

- Breastfeeding may be less convenient for the working mother;
- It is not always as easy to establish as bottlefeeding;
- Fathers and babysitters are not able to do it;
- Breastfed babies may wish to feed more often than bottlefed ones.

Bottlefeeding

Advantages

- The technique of bottlefeeding is easier to learn;
- Mothers know exactly how much milk their baby is getting;
- Fathers and babysitters can help feed the baby.

Disadvantages

- Infant formula milk is more expensive;
- Preparation of milk and bottle hygiene can be time consuming;
- There are no protective properties in formula milk;
- The emotional reward of breastfeeding will be missed.

Some further points
There is no truth in stories that breastfeeding protects against cot death. There may, however, be an advantage in breastfeeding a baby who stands a strong chance of developing an atopic condition such as asthma or eczema because of a strong family history of these disorders.

A positive two-way relationship
The main advantage of breastfeeding is the development of a two-way mother–baby relationship whereby both participate in this pleasurable process. Because of the closeness and the physical contact, the mother has more feeling and awareness of her baby's mood, temperament, and health. If this successful union cannot be achieved and if the mother derives no pleasure out of it, she should change to bottlefeeding. The chances are that both she and her baby will be happier as a result.

Problems

If you are breastfeeding and having difficulty, the midwife or health visitor are vital allies—a visit to the doctor's surgery cannot usually serve to diagnose the cause of problems. If technique is at fault, study of a feed may help. The breast may be too full or there may be insufficient milk. The baby may not be "latched on" properly. The mother's nipples may be sore or cracked. Perhaps the mother is over tired and stressed. This reduces the amount of milk she makes thereby causing added anxiety that further diminishes the supply. Babies should be demand fed, which is the way nature intended it. The problem with breastfeeding, as practised today, is that babies were never meant to wait three to four hours before their next access to the breast, lying horizontally between times. It is important that mother and health visitor discuss and agree whether the objectives of successful breastfeeding can be achieved, and if not switch to the bottle.

More about bottlefeeding

If you have elected to bottlefeed, this is a reasonable decision and should not be regarded as second best—certainly the milk isn't. Feeding time must be regarded as a time of contact between mother (usually) and baby, when he is held and cuddled and kissed, with as much eye to eye contact as possible. I believe that one positive advantage of bottlefeeding is father's involvement. Why shouldn't he bond with his little one too?

Milks suitable for babies and young children

Baby's age 0 – 6 months	6 months – 1 year	1 – 2 years
Breast milk + vitamin drops	Breast milk + vitamin drops	Follow on formula
or		
Whey based infant formula (such as SMA Gold Cap, Cow & Gate Premium, Aptamil, Osterfeed)	**or**	**or**
or		
Casein based infant formula such as (SMA White Cap, Cow & Gate Plus, Milumil, Ostermilk Complete Formula)	Infant formula	Whole cow's milk + vitamin drops
or		
Soya based formula for babies allergic to cow's milk (such as Wysoy, Cow & Gate Formula S)	**or** Follow-on formula milks (such as Progress) **or** Whole cow's milk + vitamin drops	

Formula milks

Whichever of the popular brands of formula milk is chosen, they are essentially the same. All the manufac-

turers market at least two milks. The first is a whey-based infant formula which contains all that is necessary for the first year of life (of course some solid foods should be introduced in addition from months 4 to 6 onwards). The second type of formula is casein (curd)-based and is advertised "for use when baby does not seem satisfied". This is a marketing device—a means of selling more milk. The formula has never been shown to be more "satisfying" but such is the competition among manufacturers that if one company markets a milk for unsatisfied babies all the others will too. So don't be tempted to blame the formula for any problems and keep switching milks, and always discuss any changes you propose to make with your health visitor.

Some manufacturers also make a soya-based formula for babies who are allergic to cow's milk. Do not give this to your baby in order to *prevent* any possible cow's milk allergy: only use it on the advice of your health visitor or doctor.

A special formula milk is now available for babies older than 6 months. It should not be given to younger babies nor should you give ordinary doorstep cow's milk before this time. No child under 2 should be given skimmed milk. The table gives details of milks suitable for babies and very young children.

Weight gain

Weighing is one very simple measure of health in a baby, especially in conjunction with measuring him, but remember that each baby is an individual and babies do grow at different rates.

Babies usually lose a few ounces at first but it should not be more than 5 to 10% of their birthweight and they should be back to birthweight by the 6th or 10th day. In the first 3 months an average baby gains 5 to 7 oz (150 to 200 g) each week and in the second 3 months about 5 oz (150 g) each week so that they have doubled their birthweight by the age of 5 to 6 months.

Vitamins, iron, and weaning

The Department of Health and Social Security lay down *guidelines* as to how babies and children should be fed. Included in these guidelines are when to give vitamins and iron. Doctors recognise that supplements may be given unnecessarily, but they do no harm and in attempting to generalise, the DHSS will inevitably recommend supplements to "groups" of babies. Here are the suggestions:

Premature babies
Babies born more than three weeks early need extra iron and vitamins until they are established on solids.

Breastfed babies
These babies need vitamin D and fluoride. European babies, when established on solids, can drop the supplements. Asian mothers may not have as much vitamin D and calcium in their bodies and if the babies are not exposed to sunshine, extra vitamin D should be given until the age of 2 years.

Babies on infant formulas
Formula fed babies will receive the vitamins through the milks but this is *not* so if ordinary cow's milk is used.

Babies on vegetarian diets
It is particularly important that babies on vegetarian diets be given an infant formula milk for their first year of life. If they are breastfed initially, ordinary cow's milk should not be used as follow up. All babies of vegetarian mothers or who will be vegetarians themselves, should have vitamin drops from age 1 month until they are 2 years old.

Vomiting and possetting

It is very distressing to see your little baby being sick. You may feel that this tiny body cannot survive without the nourishment of milk and if you have breastfed, there may be a feeling that he is rejecting your milk or your milk is not suitable. These emotions are quite understandable, but illogical. To a baby, vomiting is not the catastrophe that it is to his mother. To an adult, vomiting is very unpleasant—to a baby it's part of life and some even do it deliberately. There are, however, two conditions I would like to mention here in connection with vomiting.

Intestinal blockage

Some babies are born with a blockage in the bowel. If the blockage is high up, the vomiting will occur on the first day and will be bile (green) stained. If the blockage is lower down the bowel nearer the back passage, the stomach will usually blow up and vomiting will take place on the second day. There will have been no significant bowel movement. An intestinal blockage will be obvious, therefore, in the first two days and most mothers and babies will have not been discharged from the maternity unit by then.

Pyloric stenosis

Pyloric stenosis is a condition in which there is a narrowed outlet to the stomach. This problem is not normally evident before the second week of life. It usually occurs at about 6 weeks of age and is more common in boys than girls. Pyloric stenosis may be suspected if vomiting is very forceful—if for example, at the end of a feed the milk is projected some distance out of the mouth like a fountain. The diagnosis is confirmed by feeling the baby's stomach while he feeds: there is a small lump in the upper part of his tummy just as he vomits. A simple operation cures pyloric stenosis. The condition is not dangerous so there's no need to call the doctor in the night but if your baby vomits in a "projectile" way for a whole day, then you must get medical help.

Possetting (gastro-oesophageal reflux)

The human body is amazing. I remember once in my university days standing on my head after drinking a pint of beer in a childish sort of team race. None of the team vomited (it was early in the evening) which shows that children and grown-ups have a valve mechanism at the bottom of the gullet (oesophagus) where it enters the stomach. When the valve is leaky, this causes backflow of the contents of the stomach into the oesophagus giving heartburn or vomiting. If part of the stomach lies in the chest, not the abdomen, this gastro-oesophageal backflow (known as reflux) is caused by a so-called hiatus hernia. The point of this medical background is that gastro-oesophageal reflux is very common in babies because of an undeveloped valve system at the bottom of the oesophagus. The typical baby feeds well and during, or at the end of a feed, may bring up a little milk. All babies do this to some extent but the "possetter" will do this half an hour later while lying in the cot. This sort of baby is ruinous on clothes and carpets and his parents have a characteristic milk stain down the back of their left shoulder!

What to do

There are two things to do. One is to ignore the problem, live with it in the sure knowledge that it will improve. The other approach is to thicken feeds and most parents who get as far as seeing me have gone beyond reassurance. There is no need to treat the baby if weight gain is adequate, it proves that the vomited milk was extra to requirements. Which thickener one chooses depends a little on age. There are at present two—one is gelatin-based and is called Nestergel, the other, which is easier to dissolve, is called Carobel. Both work by thickening the feeds which presumably then sit more firmly in the stomach making reflux more difficult. You must follow the instructions carefully, particularly with Nestergel, as it clumps if given in excess and makes the feed set like a jelly. Remember too that a larger hole will be required in the teat. Another preparation, particularly for babies over 1 month of age, is Gaviscon, a powder which seems to thicken feeds but actually works by a different mechanism. This is equally effective and may be used for the breastfed baby. Obviously breast milk cannot be thickened, but it is possible to dissolve, say, one third of a sachet of Gaviscon in a little water and give this before a feed. Introduction of solids often helps (but these should not be given before 3 months).

At an angle

Finally, babies who posset shouldn't lie flat after their feeds. In an ideal world they would be nursed in an upright position for 10 to 15 minutes and then placed in a chair that keeps them semi-upright. This is easier said than done, for the little ones slither down ending up at a strange angle certainly not designed to help vomiting.

Sit it out

My advice on vomiting is that if the baby's weight gain is adequate and he is a happy smiling chap, sit it out

because the chances are it will have gone by 6 to 9 months.

And check the feed volume

The milk requirements of a normal baby are 150 ml/kilo per day or 2¼ oz/lb per day. Calculate the amount your baby is actually given in 24 hours and if your mathematics shows him to be taking much more than this and he's being sick, then you are overfeeding him.

Bowels

I regard bowel actions as very personal and it is unusual to discuss the subject outside the medical arena, unusual that is unless you are a baby. This is because for a large part of their life babies either sleep, feed, pass urine, or open their bowels. The fact that a dirty nappy is involuntarily inspected at each change may lead many mothers to the doctor, worried about what could be a normal variation.

Normal bowels

It's pretty obvious when a baby is opening its bowel. The concentrated expression, the red or even blue face, and the explosion in the pants tells all assembled that nature has worked. I am not worried about a history of "straining" when opening the bowels unless the baby's stools are rock hard or there is bleeding from the back passage. Breastfed babies are so variable that it is virtually impossible to describe the normal bowel action. It is usually looser than normal—and may be very loose indeed. In the first month the babies often open the bowels while feeding and the stool could be described as diarrhoea. It is bright yellow in colour and there may be some mucous. Later on the baby may miss days and then have a large bowel action as a result. The bottlefed baby tends to produce a more adult-like stool which is yellow brown in colour. In the summer months, when perhaps he needs extra fluids, he may be slightly constipated. The stool may be green but once again colour is not important.

Failure to gain weight and diarrhoea

This should be investigated, particularly if the baby has a badly excoriated (raw) bottom. Maybe he is allergic to cow's milk or the sugar content of the breast or formula milk.

Bleeding

The commonest causes of bleeding per rectum (from the bottom) are a crack in the anus and constipation. Examination by a doctor will confirm this, and a gentle laxative such as Lactulose is all that is needed. A small amount of blood in the stool on one or two occasions only can be dismissed. If it is a regular feature, blood tests and *x*-rays should be carried out. Sometimes gastroenteritis or even cow's milk allergy, can cause bleeding per rectum. Generally, if it is recurrent seek medical advice.

Constipation

In the first few days of life, the contents of the bowel have nothing to do with the feeding. Black sticky mucus (meconium) occupies the bowel of the baby developing in the womb and only when this is flushed out after birth can there be a change in the quality of the stool. If your baby is late in opening his bowels and he is stubborn from the word go, he needs investigating. It is particularly important if the tummy swells up or there is vomiting. If his bowels work well for a few weeks and then become less frequent, there isn't the same urgency to investigate. Traditional remedies such as adding brown sugar to the feeds are helpful. With bottlefed babies it is important to check that the feeds are not too concentrated and your baby is taking his $2\frac{1}{2}$ oz/lb per 24 hours. At 3–4 months of age the addition of solids may help the bowels and vegetable or fruit purees are better than rice or cereal for the "constipated" baby.

Crying

Crying is one of the most difficult subjects to write about. I can only give suggestions and guidelines as there are no absolute treatments and solutions. I sense that the problem of crying babies is very real in our society and I can only think that tension and lifestyle are the root causes. It is said that the babies of working African women and traditional Eskimos rarely cry. These babies seem to have constant contact with their mothers and are probably seldom bored. A baby spending the first few months of his life in the British winter, semi-isolated on the top floor of an inner city tower block may, on the other hand, have much more to cry about—as will his mother. This is why it is important to plan pregnancy, to know what to expect when your baby is born, and to try and organise your life so that you and your baby are not stuck indoors every day looking at each other.

What can make a baby cry?

There are certain situations in which a baby will predictably cry. He will cry • when he is hungry, • if he is uncomfortable, • if he has colic, • when he is bored, • if he is ill.

Hunger

Babies should be fed on demand and the breastfed baby may wish to feed more often than one who is bottlefed. Babies do have hungry days too when they want to feed more often than usual and mothers should not get into a panic and feel that they are not producing enough milk or that something else is wrong. Quite often they are particularly hungry on the 4th day of life and many develop a voracious appetite when they first get home from hospital.

At first the cry of hunger is the cry of a baby waking from sleep. He does not sound in pain but if his milk takes too long in coming the crying can build up to quite a crescendo. Feeds should be relaxed, unhurried, and enjoyable times when mother or father can talk and smile with their little one, breaking the feed so that the baby can bring up wind if he wishes. After the feed and some cuddling the baby should be propped up in a chair where he can see his mother until he shows signs of wanting to go back to sleep.

Is he uncomfortable?

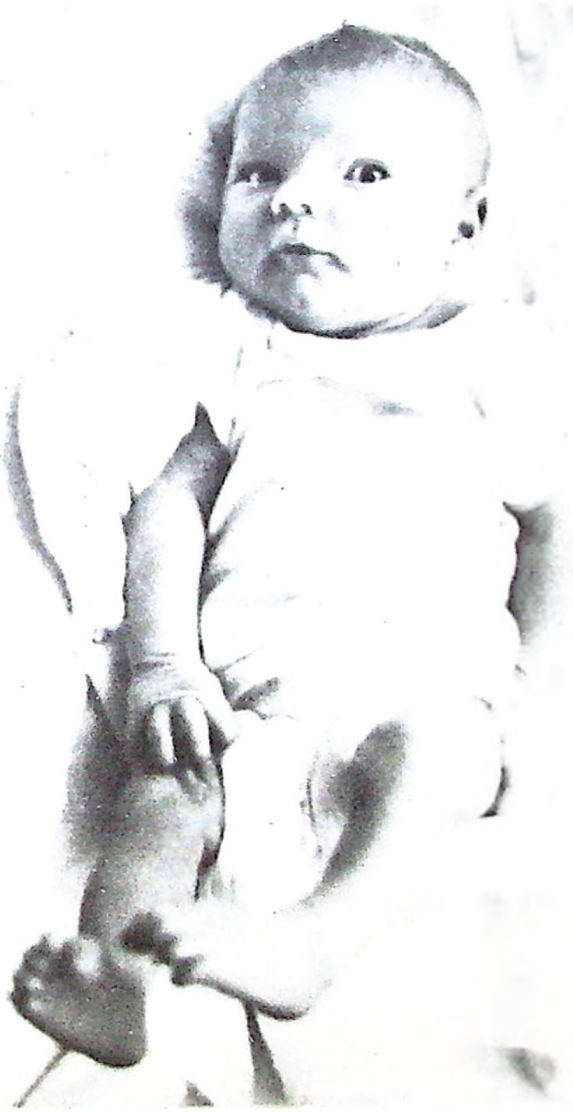
It is rather difficult to generalise about whether a baby will cry when his nappy is wet or soiled. Most small babies do not seem to care at all but a few may object.

Babies do not have a well developed system for regulating their temperature and if they are not dressed sensibly may become too hot or cold. Mothers often dress their babies too warmly, so consider how many layers of clothing you would feel comfortable in on any particular day and dress your baby accordingly.

Many small babies like to feel secure and may benefit from being wrapped in a shawl.

Colic

Colic is a name given to a condition which may begin at about 2 weeks of age and has usually stopped by 4 months. The infant screams, draws up his legs, and cannot be comforted by anything. It often happens in the early evening. We believe that colic is caused by a



spasm of the bowel, for babies with colic do seem to have abdominal pain, but we are no better at treating it now than we were 50 years ago. There are a few theories about colic, most of which I do not believe, but, for what it is worth, here they are.

Wind

Firstly, there is the belief that some babies get colic because they swallow too much air—perhaps because of inadequate winding, the hole in the teat being too small, crying too long before a feed, or because their basic personality causes them to rush everything.

Tension

Because colic usually occurs in the evening, the traditional view of the cause was that mother was in a hurry to get her husband's meal ready and therefore rushed the evening feed and offered the baby less affection so that he screamed for attention. The advice was to try and delay the evening feed until the rest of the family or husband and wife had eaten together. Quite what *Cosmopolitan* would make of this theory of angry, hard working husbands marching in and demanding their meal I cannot think. The message which does come through, however, and which holds for both the traditional family with the father out at work and the unsupported mother by herself, is that stress and rush and insufficient attention do cause a baby to cry. If you are happy and relaxed, fit and confident, then there is more chance that your baby will be contented and that colic will not be a problem.

The milk

Please do not keep changing from one formula to another because you think that another milk might improve the situation—formula milks are all very similar and none has any benefit in the treatment of colic. Predictably, the Americans have said that some colic is caused by cow's milk allergy. Hence, American babies with colic find themselves on "non-cow's milk" for-

mula, that is formula based on soya protein. I have had no success in treating colic by prescribing soya formula nor is there any scientific evidence to support this allergy theory of causation. But if you and your doctor are desperate, a soya milk may be worth a try.

Medicines for colic

If all else fails, is there any medication to offer? Merbentyl (dycyclomine hydrochloride) was always the favourite but the manufacturers were told not to recommend it for babies because of a few reports of babies becoming unwell as a result of taking it. Some doctors do still prescribe Merbentyl and I would not criticise this. Oval drops are similar and may be of help, but again cannot be recommended by the manufacturers. Quite what gripe water does, I do not know. All these treatments probably make *us* feel better because we have done something but I am not sure that the baby derives any benefit.

Other measures

Some parents give their baby a warm bath, others take him out for a walk or a drive in the car (which is fine as long as the baby's favourite crying time is not 2 am). At the end of the day, when all else fails, lie your baby on his tummy on your knees, massage his back, and count the days or weeks left until the colic phase passes, as pass it will!

Boredom

Although a small minority of babies hate being fussed, most like a lot of physical contact and stimulation. They may cry for this reason and will stop as soon as they are picked up. Once he is a few weeks old a baby will have periods of waking and may hate being left alone in a pram or cot. A harness which allows him close physical contact with his mother or a bouncing chair placed in a safe position so that he can watch what she is doing may make him happier.

Is he ill?

When your baby is inconsolable and his crying is a continuous scream, the question of illness must be considered. Whereas colic comes and goes and is suggested by the drawing up of the legs and the passage of wind down below, the pain of an obstructed bowel is more likely to be continuous. Look for other symptoms and signs: • when did he last open his bowels? • was the stool normal? • was it loose and was mucous or slime present—or even blood? • is he being sick? I am not suggesting that you can play doctor and objectively assess your own baby but if his tummy feels soft and there are no swellings in his groin such as a hernia, this is reassuring.

Whimpering

If a baby is ill in other ways the crying may be that of a moan or a whimper, not a full blown scream. The quiet, whimpering baby is, however, every bit as worrying as the screamer. When you call the doctor, it may help to have thought over the points I have mentioned: it may make the difference between being seen that night or the following morning.

General advice on crying

Get a break

Few things are as wearing and distressing as looking after a crying baby. Try to organise your life so that you can get a break from time to time to do something you want to do.

Routines

Attempt to get your day organised into a routine as soon as possible. Babies love activity and routines—they may even like the afternoon soap opera but not in preference to a walk in the pram. Inconsistency upsets a baby. If he knows that he has a bath at a certain time . . . then always goes out . . . has a feed . . . then mummy puts her feet up . . . etc, life is better for everyone. Get into a routine that suits you and stick to it.

Sleep

Sleep is another area of debate with dogma, anecdotes, and rules flying in every direction to confuse the most organised of parents. All babies have different sleep patterns and different requirements. Some newborn babies sleep almost continuously between feeds whereas others spend quite a bit of time awake. The rough pattern of the day, however, is that a baby will feed every four hours but should drop one feed in the night. With luck there will be a feed between 10 pm and midnight and he will then sleep through until 6 am. I think you are fortunate if your baby gets into this rhythm straight after coming home from hospital. It is more likely that he will want a feed at 2 am (and we hope not too much play) for a few weeks.

One cannot stress enough the importance of mother getting some quality sleep. To rise between 6 and 7 am after an awful night only to face the housework, shopping, and the baby can be an incomparably bad feeling. It may be made worse by the sight of your partner leaving for work and then complaining about a busy day when he comes home in the evening. This can be a period of strained relationships as the confused, sleepy mind is not the most understanding. If you are not getting enough sleep at night do try to take a nap during the day, rest is much more important than housework at this time.

Routines again

I go back to the statement that there should be a routine to a baby's life. If the pattern of the feed, the nappy change, the cuddle, and the song is the same, so sleep will be expected. Hence the lullaby on a string

from a plastic moon or cuddly toy tells him that this is the time he is expected to sleep because mother has other things to do, even if its only sleeping. But do remember that you cannot expect a baby who is not tired to go to sleep because you would like some rest.

Some scenarios

He is put to bed but will not sleep and screams
Ignore the crying for 5 to 10 minutes but if it persists go to see him, cuddle and calm him, and then put him firmly down again. If he goes on crying this sleep will have to be abandoned but beware, this may be the beginning of a battle which I hope you can win with firm kindness. Always try to be consistent, something which is more easily said than done.

He won't sleep but doesn't cry
This is fine but *don't* go back into the room to check all is well. When he does eventually drop off to sleep, this may be accompanied by whimpering and periodic weak crying which again can be ignored.

He doesn't want to sleep at all at night

I think most parents can live with a baby who doesn't sleep in the day so long as he is not screaming his head off at night. There are some babies who will just not sleep. I don't believe it is your fault, these babies are just a fact of life. Although if you have broken all the rules and looked in every half an hour to see he is breathing or picked him up every time he cried, then you could have brought the situation on yourself. Most families, however, have had a non-sleeper or certainly have known one. In these situations the various alternatives are:

- **Bring the baby into your bed**

I have nothing against this towards the end of his first year. It's natural for babies and children to be more secure when in the family bed but if the baby is very small, I don't think it's safe in case you smother him in your sleep.

- **Get up alternately**

This is a form of "time-sharing" where you and your partner share the shifts in the small hours of the morning. At least both of you get some sleep at some stage and you have shared the pleasure(?) of seeing the dawn rise.

- **"Knock-out drops"**

Trichlofos, chloral, Phenergan (promethazine), and Vallergan (trimeprazine tartrate) are medicines used to sedate children and they are not addictive. The problem is that they don't work on the true non-sleepers. I think they work better on the occasional basis, for example when there is a babysitter. Another problem is that the dose your baby needs is probably so great that by the time he goes to sleep, having fought the effects of the medicine, he doesn't wake up until lunch time the following day. I certainly do prescribe these medicines when mothers are desperate but their action is not impressive.

- **Company**

If he merely wants company and he's too young for your bed or that hasn't worked out, you may wish to move a temporary camp bed into the baby's room. It's possible that with you by the cot he will sleep. Once again, I don't think this is a good plan of action for the single mother but it is a desperate measure which mother and father can use alternately.

Firm handling and common sense

Remember—all these measures are extreme. Firm handling and common sense are usually all that's needed. People reading this section of the book have usually tried these, so I have described some extreme measures, not for recommendation but to prove that you are not alone if you have considered them. You wouldn't be the first parents to load the baby into a carry cot and take him out for a drive in the night. Car engines seem to put the most resistant of babies to sleep.

Some anatomical features

Head, skin, and bottom

Head

The largest part of a baby's body is his head. This is the most difficult part to squeeze through the birth canal and, of course, it sometimes gets stuck. When it comes through with difficulty, it can be an amazing shape and colour but this reverts to normal very quickly. If the baby's head does not return to the usual round form, it is possible that there will always be a tendency for a *mild* asymmetry (lopsidedness) of the face. This is nothing to do with the delivery but probably is caused by the way he was lying in the womb or one of the skull bones fusing early. By the age of 2, with normal hair growth, he will look as good as any toddler.

The fontanelles

Two holes in the skull—the fontanelles—are very variable in size. The one at the front can be quite large and pulsates with the baby's heart beat. If baby is at rest, sitting up, this fontanelle should be soft. It will be tense when he screams but not otherwise. The smaller fontanelle at the back of the head may be almost closed at birth.

Skin

A baby's skin is very delicate. If he is premature his skin should be handled very gently. The skin of a baby who stays inside his mother more than 40 weeks without growing well is sometimes very rough. The hands and feet have deep furrows in the palms and sole, and sometimes the skin peels off like sunburn. One thing you can rely on is that a baby's skin never looks the same two week's running and the speed of change is remarkable.

Spots

In the first few days of life, many babies develop minute spots. These have a white, pinhead centre surrounded by a red flare standing out from the surrounding pale skin. They sometimes look so angry that they might develop into a typical adolescent spot, but left well alone they fade away. These spots are an allergic reaction, not an infection, but we do not know to what the baby is allergic. They are equally common in breast and bottlefed babies and their medical name is erythema toxicum or toxic urticaria.

Around the same time, another common rash occurs called milia. This is on the face and particularly the nose. It looks like blocked sweat ducts and you get the impression that if you squeezed the skin, the matted sweat could be expelled—not something I would recommend. Once again this is purely a cosmetic problem, a passing phase which should be treated by sensible washing with the baby's own face flannel and drying with a soft towel. If soap is used, it must be pure and not coloured or scented.

Birth marks

A birthmark is a discoloured patch on the skin caused by pigment or a collection of small blood vessels under the skin. Most babies will have a small, pink, spidery *stork mark* between the eyes. Again, doctors have no explanation of this mark so we are happy to go along with the explanation that it is caused by the beak of the stork which bears the baby. Consistent with this stork theory are red marks (one or two) found on the back of the head, sometimes covered by hair if the baby is blessed with a good crop. Both the front and back marks may be quite prominent on a very pale baby but will have gone by his first birthday.

What does cause anxiety are the more unsightly raised "*strawberry*" nevi (marks). These are a collection of blood vessels which grow alarmingly rapidly. On the face they are so obvious that medical reassurance is necessary. Whatever the site, the advice is:

- They will get bigger before they get smaller.
- They will go grey in the middle before starting to fade.
- They will usually have gone by the age of 2.

Occasionally strawberry marks are very large, in which case they do not fade. Treatment is not easy but surgery should certainly be avoided.

Mongolian blue spots are patches of pigment over the buttocks and lower back and are common in Afro-Caribbean or Asian babies. They fade as the skin darkens.

A *port wine stain* is a red patch on the skin which is usually quite large and, because it does not disappear, can be most distressing. If the mark is very unsightly your doctor may refer you to a plastic surgeon when the child is older.

Cradle cap (scurf)
Cradle cap is a very common condition. A layer of waxy material builds up over the scalp but is stuck to it so that removal is difficult. Most babies develop a scurfy scalp in the first week or two and possibly this develops into cradle cap. It's rather like dandruff in grown-ups. The best treatment is to rub olive oil (better than baby oil) into the scalp at night and shampoo out the following day, repeating this until the cradle cap has gone. A popular shampoo for occasional but not regular use is Polytar. Very often cradle cap is associated with a skin complaint called seborrhoic dermatitis.

Seborrhoic dermatitis
This is a condition easily confused with eczema. It seems more angry and scaly than eczema and attacks the skin creases—the groin, armpits, and neck. It is particularly common in the areas under the ear lobes where cracks will appear as though the ear is starting to come off. Various creams are available. The basic cream is a moisturiser such as E45 or oily cream. If the area of skin is infected, an antibiotic cream is appropriate. When more severe, a steroid ointment or a coal tar and salicylic acid preparation can be used.

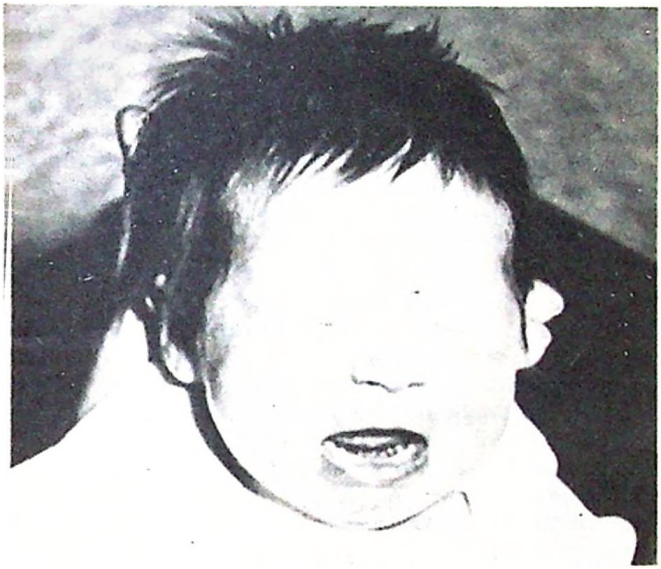
Eczema
It is unusual for severe eczema to affect a baby in the first 3 months. If it does, there is usually eczema in the family. Mothers point out patches to me on their babies' skin, anxious that their children may be developing eczema. All that is usually necessary in these cases is a moisturising cream. For true eczema, however, a steroid cream—the best being 0.5% hydrocortisone—is normally required. Certainly you should ask advice from the doctor about severe eczema, and prep-

arations you can buy "over the counter" from the chemist should not be used. If the eczema or seborrhoic dermatitis coincides with the introduction of cow's milk after breastfeeding has stopped these skin rashes may possibly be caused by cow's milk allergy. If this is the case I would try a formula milk which is soya based such as Cow & Gate S Formula or Wysoy, or a *very modified* cow's milk formula such as Pregestermil. Some babies grow out of their eczema rapidly. Some do not. It's not possible to generalise.

Bottoms

I wouldn't mind betting that if grown-ups revealed their bottoms to the world as much as a baby is forced to, there would be a fair amount of pathology on display. My point is that because this area of a baby's anatomy is inspected so regularly it is the source of much concerned discussion.

There are two sorts of nappy rashes. One is simple soreness caused by either a sensitive skin or infrequent nappy changing. The other is the result of an infection called thrush (Candida moniliasis). For the former washing, drying, the application of a barrier cream such as zinc and castor oil, and frequent nappy changing are all that is necessary. There are many excellent creams available—find one that works for your baby and stick to it. If the rash is slow to clear despite all this and if it spreads and scales or there is slight blistering, thrush is suggested. The two creams which are then effective are either Nystan (nystatin) or Daktarin (miconazole). Take a look in your baby's mouth: if there is a white film on the tongue, cheeks, or gums he has thrush there too. In this case he needs both the skin cream and a suspension for the mouth. A five day course should clear things up but make sure the teats of his bottles are sterilised well and try to make him do without a dummy (if he uses one) until the infection has cleared.



Eyes, ears, nose and mouth

Eyes

Babies can see as soon as they are born. They are short-sighted, however, and can only focus if you place your face very close to them. Do try this with your baby. He may fix on your eyes and even follow but I assure you that he will have no interest in a cuddly toy. At the age of 8 to 10 weeks most babies definitely follow movement and at this stage it is easier to see whether there is a squint (a condition in which one eye seems to wander and not focus). One way of telling is to look at the reflection of light (for example a window) in the baby's pupils (the black part of the eye). If the reflection of the window remains in the same part of the pupil in both eyes whichever way the eyes are looking, then the baby has no squint. You should consult your doctor if the

apparent squint persists after the baby is three months old.

Sticky eyes

In the first week or two babies will often have a sticky eye. This happens for a variety of reasons:

- Babies spend a lot of their time with their eyes closed, causing the secretions to matt the lids together.
- The tear ducts draining from the eye into the nose tend to be blocked in babies.
- The eyes may be affected by organisms picked up from the birth canal during delivery.

If the eye reddens or the discharge is profuse, this needs medical attention. Ideally, a swab is taken and an antibiotic eye preparation such as neomycin (nystatin) or chloramphenicol is given. Very occasionally an eye infection occurs during the first week of life and is resistant to these antibiotics. In this case special swabs are made to confirm an unusual infection called clamydia. In most babies sticky eyes are not caused by serious bacterial infections and all that is necessary is cotton wool, boiled water, and sensible bathing of the affected eye.

Ears

Newborn babies can hear—they respond to sound by blinking, starting, or drawing in breath. Babies can get ear pain caused by infection and this is often a reason for crying and waking at night in a baby who otherwise sleeps well. Older babies may pull at their ear when it hurts. You should never use cotton buds to clean wax out of your baby's ear. This is unnecessary and may only serve to push it further in.

Nose

There cannot be many babies who have not had nose drops from time to time. This is probably the most overrated treatment in medicine. It is true that a cold will cause snuffles and difficulty with feeding, but what most parents don't realise is that nose drops themselves

can irritate the lining of the nostril, making the problem worse. Never use nose drops without your doctor's advice.

Mouth

If a tooth is present at birth it should be removed. This tooth is an extra, two more will follow, and it has no significance. An apparent tongue-tie, where the connection of the underside of the tongue with the floor of the mouth is short, has no importance in the first year. It is never the cause of poor feeding and by the age of a year it should hardly be noticeable.

Thrush

I have already mentioned the typical appearance of thrush—it looks like milk remnants on the gums, tongue, inner cheek, or roof of mouth but whereas milk will easily separate from the tongue or inner cheeks by gentle manipulation with the little finger, the thrush fungi are firmly stuck. Thrush can certainly be a cause of poor feeding. It is usually associated with bottlefeeding where bottle hygiene is not perfect and antibiotics such as ampicillin may predispose to it. Thrush is easily treated—Nystan(nystatin) suspension or Daktarin (miconazole) gel is placed in the mouth after meals and should clear up the condition in a day or two.

Umbilicus

After delivery, the umbilical cord, which joins the baby to the placenta is clamped and cut. It withers and falls off towards the end of the first week by the process of dry gangrene. This sounds awful but remember that as long as it doesn't get infected, there is no problem. Once again cleanliness is everything. You should clean the area and umbilical stump daily but over liberal use of powder (Sterzac) should be avoided: sometimes you see the powder all caked together at the base of a smelly cord. If the skin around the naval becomes red and shows signs of infection, contact the doctor.

Umbilical granuloma

Sometimes the umbilicus remains "sticky". When the skin around it is stretched to give a better view of the centre, a small knuckle of material can be seen peeping out. This is the base of the umbilical cord which has not totally disappeared and the question arises as to which, if any, treatment is necessary.

There are three approaches to these so-called "granulomas". Firstly, there is a silver nitrate stick with which to cauterise or burn the tissue (as with warts). Secondly, a ligature can be tied around the base to ensure that the stump falls off. Thirdly, do nothing. All three approaches have merit but if leaving alone for two to three months works, that is what I would do.

Circumcision

I would not enter into the discussion of whether routine circumcision is beneficial or not in the long term. In the United Kingdom circumcision is not performed under the NHS on cultural or social grounds and Jewish and Moslem communities have to make their own arrangements.

The foreskin is normally adherent to the glans (tip) of the penis in newborns but it can usually be drawn back fully by the age of 3 years. The reasons for circumcision at any age is recurrent infection under the foreskin or ballooning up of the foreskin when urine is being passed. It is unfortunate that circumcision is left until later in many children who develop these problems. I feel that complications are largely preventable by good hygiene and correct observation of the penis by the parents. There is a school of thought that says leave the foreskin well alone and never try to force it back. I would not totally support this. I believe that from time to time (eg at bathtime) the retractility of the foreskin can be gently tested with the smallest bit of pressure. The golden rule is not to force the skin back or to hurt the baby. This inspection may prevent infection starting.

More about illness

The most worrying thing for parents to decide is whether their baby is ill. The main difficulty arises when a baby doesn't seem right, he's crying too much, but there is nothing very specific to describe. In the middle of the night the doctor may ask several questions which are pointers to specific baby conditions. Most serious conditions in babies arise from infections, usually virus infections of the chest.

Conditions requiring surgery

Strangulated hernia and pyloric stenosis

Conditions requiring an operation are unusual but worth mentioning. Firstly, a baby's bowel may be obstructed because of a hernia. Babies born prematurely are prone to hernias in the groin. In boys, examination shows a swelling in the scrotum which is considerably larger than the normal testicle and is tender to touch. Baby girls may also have a strangulated hernia but it is not so common. Because of the blockage the baby's bowels may not have opened for some time and vomiting will also develop. So always have a look in the groin for unusual swelling. The second condition is pyloric stenosis which is described under the section on vomiting.

Intussusception

Finally there is a peculiar condition of the bowel called an intussusception. In this case, the baby seems colicky—drawing up his legs and screaming with stomach ache. Vomiting or the passing of blood or mucous from the baby's anus shows that this is not colic. So always think about your baby's bowels if you are worried and if the last bowel action was normal be reassured.

Medical conditions

The "medical", as opposed to "surgical", conditions are less clear cut. Firstly, if you have a thermometer, take your baby's temperature. If you haven't got one, don't go out and buy one—I'm not a great advocate of home temperature measuring as it doesn't add a great deal to home diagnosis. In the hospital, babies always have the indignity of their temperatures being measured in their rectum because the thermometer is at risk of being swallowed in the mouth or disappearing from under the arm. In Europe, a great deal of use is put to the bottom end of babies—not only are temperatures measured there but half the common medicines, particularly those designed to bring down fever, are introduced to this portal of entry. Nevertheless, if by some means you record the baby's temperature and it is high, it is of some importance. Toddlers have always got running noses and high temperatures but the same is not so for babies.

A smile reassures

Secondly, and I believe most importantly can you get your baby to smile or laugh? I've asked many of my colleagues if they have ever seen an ill baby smile: the answer is usually no. If I can make a baby smile, I practically always reassure the parents that he has nothing serious. Another important question is, what is the baby's mood? Irritability, resentment of movement, and drowsiness are important signs of illness. The words irritability and drowsiness are of particular importance when talking to a doctor.

Gastroenteritis

One of the commonest illnesses, summer or winter, is gastroenteritis. The hallmark of gastroenteritis is diarrhoea, which may or may not be accompanied by vomiting. If the stools are frequent and loose and there is blood or mucous in them, the gastroenteritis is accompanied by stomach ache. It doesn't matter what the offending bug is, the treatment is clear feeds (no

milk) given little and often. There are two or three commercial preparations on the market to add to water to give the correct sugar and salt mixture—Dioralyte and Rehidrat are the best known. Please never add double the strength on the mistaken grounds that it will get baby better twice as quickly. I have known these powders added to milk when the instructions have not been followed. One or two days on clear feeds should be enough before dilute milk is reintroduced into the baby's diet. When breastfeeding, extra fluid can be given using one of these preparations but don't stop giving breast milk.

Bronchiolitis

Between October and February there is usually an epidemic of bronchiolitis. This illness is caused by a virus called the respiratory synctial virus against which no vaccine has yet been manufactured. The poor little babies cough, wheeze, and vomit and often find their way to hospital. Mild cases can be treated at home but hospital admission is often necessary so that these sick babies can be fed through a naso-gastric tube and for general observation.

Fits

Finally an important symptom in a baby is abnormal jerky body movements or eye rolling. Fits in babies under 6 months are not the harmless, feverish convulsions that affect the older age group, and always need investigating. Sometimes it is difficult to know when a movement is normal or not. The quivering of the ankle while asleep (like a cat dreaming) is common; repeated jerky movements, particularly if the baby seems elsewhere, are definitely not normal.

A potted list

This is a potted list of what can go wrong and what the symptoms are. So, if your baby is screaming and you are worried remember that if his bowels are normal, he's not coughing, he's taken his feeds, and he smiles he is probably fine.

Immunisation and developmental surveillance

Please get your baby immunised. Immunisation against diphtheria, tetanus and pertussis (whooping cough) (known as DTP) and polio (by mouth) is usually given at 3, 4, and 9 months. But there may be slight variations throughout the country. Measles immunisation is at 15 months. Premature babies are immunised at the same stage from the date of birth and not from when they should have been born. Children at high risk are offered BCG against tuberculosis at birth. This infection produces a slight lump which leaves a very small mark. The only reasons for not giving tetanus, diphtheria, or polio are illness at the time immunisation should take place or a proved lack of resistance to infection. There are very few contraindications to whooping cough vaccination—the only ones being • a reaction to the previous injection; • convulsions (fits) in the baby or close family members; or • illness on the day of vaccination. A simple runny nose, egg allergy, hay fever, asthma, or eczema are not reasons for not immunising. You will be given an immunisation record card which you should take to the clinic when you go so the doctors have a record of the immunisation status of your baby.

Developmental surveillance

In Britain all babies are examined at specific ages so that any abnormalities can be detected early and mothers can discuss any anxieties they may have. I have already discussed the assessment that every newborn baby has, subsequent examinations are undertaken either by the family doctor or the community medical officer at the child health clinic at 6 weeks, 7 or 8 months, and again at 18 months.

Cot deaths

One of the saddest comments on progress made in child health is the inability of the medical profession to find the cause of cot deaths or sudden infant death syndrome (SIDS). Statistically, about 4 in every 1000 babies will die suddenly before the age of 1 year, usually before 6 months. If there has already been a cot death in the family, there is an increased (though not high) chance of it happening again. Hence there is a population of theoretically "at risk" babies, the brothers and sisters of the ones who have died. Many parents are now loaned monitors which make a loud bleep when, and if, the baby stops breathing. These monitors are not of any proven benefit but most parents feel better for having one. Some parents are also loaned special scales to weigh at risk babies as an association has been noted between failure to gain weight and cot death.

Causes

The possible causes of cot death are varied and unproved. They include milk going down the wrong way, sudden irregularities of the heart rhythm, babies unaccountably forgetting to breath, serious virus infections, rare congenital inabilities to metabolise food, and babies being too warm or too cold. In a nutshell, despite strenuous efforts doctors have not come up with any one solution, which implies there are a variety of factors which have the final, common effect of making the baby forget to take its next breath. All that parents can do is to know the signs of illness in their baby and seek medical attention when necessary.

Babies are wonderful, and at the same time terrifying. New parents can feel quite overwhelmed by the responsibility of looking after such a tiny, fragile looking creature. **Your new baby**, by consultant paediatrician John Bissenden, aims to help parents through the early months. It gives guidelines on caring for new babies and considers areas that cause greatest concern such as feeding difficulties, sleeping, and crying, and the problems of illness and babies in special care units.

Rs. 15.00

J-622

JAICO BOOKS