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 chronic infections is not new. However, the results of the MRC's Concord trial in childhood acute lymphoblastic leukaemia and more recent studies failed to indicate any significant benefit of BCG immunotherapy. In adult myeloid leukaemia complete BCG/allogeneic immunotherapy stimulated strong cell mediated immunity to donor, but not to autologous leukaemia cells, 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, there is much to consider and caution is required as to the use of prophylactic BCG vaccination as a preventative measure in childhood leukaemia.


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. 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 with chronic persistent cough or postnasal drip. Chronic cough, when wheezy, 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 definitive bronchospasm. For persistent cough a trial of inhaled β2 agonists or inhaled steroids is logical and potentially less harmful than other common treatment approaches, such as antibiotics, or even surgical ear, nose, and throat procedures.

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1 McKenzie S. Cough — but is it asthma? *Arch Dis Child* 1994; 70: 554.

**Growth standards for infancy**

**Editor,—** We fully endorse the views of Wright et al on the need to develop new growth standards for infancy. The comparison of their Newcastle data with widely used standards and with the Cambridge Infant Growth Study illustrates this need succinctly. The Cambridge study is not, however, confined to breast fed infants. Although a high proportion (90%) were initially breast fed, 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 rate than the bottle fed group compared with those breast fed bottles. 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 (0-84) kg, and the Z scores 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 than were those of 10-20 years ago when the standards were prepared. 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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