

Nov. 1978 \$1.00  
Mothers' Opinions: Test-Tube Baby Poll

# Parents

Special Health Issue



Your child will probably catch seven colds this year.

Prevention is almost impossible, but you can keep sniffles and sneezes from developing into a more serious illness.

# Cold Comfort

By Melinda Blau

The 1978-79 cold season is in full swing. By the time this magazine hits the newsstands, most children will have had their first cold and can expect another six before the year is over—as many as twelve if they live in crowded urban settings.

“Being alive is the only criterion for susceptibility,” says Dr. Michael Katz, director of Baby’s Hospital, Columbia Presbyterian Medical Center. “Anyone given a sufficient dose of virus will get a cold.”

The “virus” Dr. Katz refers to is not one but more than a hundred different kinds—hardy germs strong enough to survive temperatures as low as negative-200 degrees Fahrenheit and to withstand pressure 100,000 times the force of gravity. Such viruses make American children miss 58 million days of school and suffer untold hours of misery.

Children under six average three times as many colds as most adults. The reason is simple: there is more human-to-human contact among groups of children and therefore a greater chance of their being exposed to a cold virus. (That also explains why parents have more colds than do other adults.)

Although cold viruses strike at any time of year, researchers have identified three peaks in the September-to-May “season”: the greatest number of colds occur in September and October when children go back to school, but the worst colds are in January and February when viral and bacterial complications—such as flu, tonsillitis, bronchitis, or pneumonia—are more likely to occur. In late March and April colds peak again and then fall off during the summer months.

It’s no accident that the cold season coincides with the school year. Classroom air is filled with viruses spread by a roomful of sneezing and coughing children. Dried viruses on wood, Formica, or

other less porous surfaces remain active for as long as three hours. If a child touches a virus-coated desk and then rubs his eyes or puts his finger in his nose or mouth, he may “inoculate” himself, allowing a cold virus to invade his body.

And invade it does. The virus lodges in the mucous membrane of the child’s throat and begins to multiply. One to three days later, an “army” of viruses bursts forth; it travels to all parts of the respiratory system, turning the child into a “carrier”—several hours before he actually appears sick. Finally, the symptoms blossom, a sign that the body is fighting back. And within a few days, the cold runs its course. The child will then be immune for the next four to six weeks, but only to a specific virus—the one responsible for that particular cold.

Then there’s the question of resistance. Why do some children get more colds than others? We already know some factors: age (children under a year are less resistant than older ones) and birth order (firstborns are very prone to colds at the beginning of their school careers because they’re bombarded by so many new viruses). That’s also when their younger brothers and sisters are most likely to catch a lot of colds. Also, boys under three seem to get more colds; after that, girls take the lead.

In trying to shed new light on individual susceptibility, several studies have shot holes in many of our favorite cold myths: getting chilled or sitting in a draft does not increase one’s chances of catching cold, nor are temperature and climate necessarily determining factors. In one study, volunteers were deprived of sleep for 56 hours; they caught colds no more readily than well-rested people. Even “fitness” is no guarantee against colds, according to a group of English researchers who studied more than 9,000 people over a twenty-year span.

Nevertheless, fitness certainly can’t do a child any harm and, as the English researchers put it, “The weakly and tired patient fares worse than the fit.” So when most pediatricians are asked about cold prevention, they fall back on the kinds of answers

Melinda Blau specializes in medical articles.

# Does Your Bed Belong To Baby?

**Yes, you can take your child into bed with you. Sometimes.**

**By Mary B. Hoover**

It's a familiar scene. Early in the morning, your child ambles into your bedroom. You're still sleepy and the child is feeling drowsy and affectionate. Just as you are tempted to take him into bed with you for a cuddle, Dr. Spock's warning flashes through your mind: parents should "not take a child into [their] bed for any reason."

Or, your child awakens in the middle of the night with a nightmare, and refuses to settle down again. If only to get a little rest before dawn, you'd like to let him sleep with you—just this once. Again, the dogma with which you were raised conflicts with your instincts. What should you do?

The no-kids-in-bed rule stems from the psychoanalytic notion that children must be shielded from any parental behavior that might be "sexually arousing" or "seductive," and from the risk of witnessing parental intercourse.

We do know from the work of anthropologists that in many other societies children customarily sleep in the same room with their parents, often sharing a bed with them for the first few years of life. We also know that these children grow up noticeably exempt from the sexual disturbances and inhibitions common in this country. We know, too, that young children—indeed people of all ages—have a need for affectionate physical contact that all too often goes unmet in our culture. Helping adults feel free to touch each other in a friendly fashion is big business here.

This does not mean that we should adopt the sleeping arrangements of simpler societies, only that many parents have an unwarranted fear of ever letting a young child cuddle up next to them in their bed. Parents can sense exactly how to keep such contact within appropriate bounds, so that it pro-

notes peaceful relaxation and family unity, not excitement. There is no danger of accidentally overstimulating a child. The child's reactions tell us precisely where to draw the line.

So don't feel hesitant about welcoming your child into your bed for a morning cuddle. It's a fine way to start the day. And, from the standpoint of the *child's* welfare, there is no reason not to take a frightened toddler into bed with you so that the family can get some rest. The only danger here is that each time you do this it becomes progressively harder to get your child to sleep in his or her own bed—and there goes your privacy. (It should be noted that Dr. Spock presents his "rule" in this context.)

A number of parents who have more than one child have found that if their children share the same bedroom, or are free to go to each other's rooms when they awake frightened at night, they get through the years from two to six, when bad dreams are frequent, with very few episodes of crying for parental comfort.

If you have an only child, however, or if your children for some reason can't relieve each other's night fears, then you should be wary of resolving this problem by taking your child into your

bed. Doing this once in a while is no hardship for parents, nor is it likely to be habit forming for the child. But if the problem occurs two nights in a row, parents should explain to the child that ordinarily one sleeps in one's own bed—and settle the child down there.

In tribal societies where all family members sleep in the same room, children are *not* routinely exposed to parental lovemaking. The custom is for adults to repair to an isolated spot in the bush to have intercourse in privacy. No doubt children do sometimes witness the act, by accident or otherwise, as happens here, and they are apparently none the worse for it.

What to do if your child walks in on you when you are having intercourse? Aside from making a mental note to lock your bedroom door next time (if it has no lock, install a hook-and-eye latch), just keep calm. Children usually recognize they have intruded and leave. If this doesn't immediately occur, a matter-of-fact, "Mommy and Daddy want to be alone now; we'll see you soon," will suffice. If the child asks later what you were doing, you can say, "We were making love." You need not offer more information unless it is requested. If it is, just answer each question simply, but honestly. ●



**Mary B. Hoover** is the author of "The Responsive Parent," published by Parents Magazine Press.

they've always given: (1) "reasonable" hygiene, such as washing before meals to intercept viruses normally transmitted by hand; (2) the proper amount of sleep, which varies from child to child; (3) using a humidifier, especially in winter when dried out nasal and throat passages are less resistant to infection; (4) avoiding crowds; and (5) good nutrition, including a daily multivitamin.

If preventive measures seem ineffectual, cold remedies offer even less hope. Nothing can cure the common cold; the best we can do is relieve its nagging symptoms. Pediatricians vary widely in their advice to parents, but here is a composite of the measures most often recommended.

#### **For stuffed noses:**

Would you believe—chicken soup? Actually, any liquid will increase the amount of respiratory secretions, dilute the child's mucus, and possibly offer some relief. Running a humidifier or vaporizer in the child's room has the same effect.

Because infants don't normally breathe through their mouths, their stuffed noses can be particularly troublesome. Parents can gently suction a baby's nose with a nasal aspirator. Older children can blow their own noses, but should be cautioned not to blow hard and to blow with both nostrils open. Shutting off one nostril puts too much pressure on the other one and can force mucus into the Eustachian tube. This often causes otitis (ear infection), the most common by-product of childhood colds.

Nose drops, most doctors maintain, are not worth the short-term relief they provide, and repeated use tends to irritate the mucous membrane.

#### **For sore throats:**

Doctors debate the value of gargling with warm salt water to relieve a mild sore throat, but they do agree that it can't hurt. The same can be said of countless folk remedies that, at the very least, make the parents feel better. When a sore throat lingers past the first day or two of a cold, however, or becomes more painful, it may signal the beginning of a strep-throat or other more serious infection.

#### **For aches and fever:**

As the commercials so often remind us, many doctors recommend aspirin to relieve the aches and pains of a cold. But some pediatricians suggest it only when the child's temperature is over 101 degrees Fahrenheit; others prescribe aspirin regardless of fever. In either case, when a child has been taking aspirin, parents should be extra careful about keeping him isolated. According to a study done in 1975, aspirin increases the amount of virus shed in nasal secretions and therefore makes an aspirin-treated cold more contagious to others.

#### **Medication:**

Antibiotics do nothing to cure a cold, nor will they work as a preventive measure.

Antihistamines, long favored for the treatment of allergies, can relieve similar symptoms in cold-sufferers. Antihistamines won't shorten the cold, though, and they often make the child drowsy.

As for vitamin C, by now most doctors don't believe in large doses as a preventive measure, although some do acknowledge that it may have an effect on how serious a cold is or how long it lasts. Still, there is debate over how much vitamin C should be given, especially since no one knows the long-term effects of large dosages on children.

#### **When to call the doctor:**

There's no reason to call a doctor at the first sign of a cold. However, medication other than aspirin should *never* be given without consulting a professional. Likewise, if a child's fever gets very high or lasts beyond the first day or two, it may be a sign of a secondary infection. The same is true of any unusual changes in the child's condition—if he doesn't awaken as easily as usual, complains of an intense headache or severe pains elsewhere, has a prolonged loss of appetite, or vomits repeatedly.

Most colds end as colds, seven to ten days after a child first contracts a virus. So when a "cold" does go on for more than two weeks, most doctors investigate further. "When parents tell me, 'My child has had this cold for the past five weeks,' I usually look for something else," explained Dr. Stanley E. Read, assistant attending pediatrician for New York Hospital. The "something else" could take many forms—infection, an allergy, or, in rare cases, a problem with the child's immune responses.

Dr. Read, who also does research in the field of immunology, doesn't see much hope for the development of cold remedies or a preventive vaccine. Actually, "vaccine" is a misnomer, since it implies isolation of a specific virus. And with a hundred types of viruses, that is impossible.

Researchers have discovered a natural body protein—interferon—that seems to be an effective cold fighter. But no one has figured out how to produce interferon synthetically, so the present costs of such treatment is extremely high—around \$100 a day, a steep price tag for a relatively harmless, illness. "It's not really practical to spend a lot of time on the common cold—there are more serious diseases to work on," admits Dr. Read.

In the meantime, young cold sufferers and their parents will have to make do with a "prescription" that dates back to the ancient Greeks. Said the philosopher/physician Empedocles around 450 B.C., "Wipe your nose and don't complain." ●

## Artificial Fertilization: The Newest Therapy (Continued)

environment," as Professor Andrews terms it. This environment includes substances like sugars, proteins, other nutrients, and hormones.

When the fertilized egg has grown to the sixteen-cell stage, it is ready for implantation in the uterus, either through the abdomen or through the vagina and uterine cervix.

### Hazards and risks.

Needless to say, in this entire process a great many things can go wrong. If the exact moment of ovulation is missed, an egg may not be obtained. Or the egg may not be fertilized by the sperm. Or, if fertilized, the egg may not develop to the blastula, or early embryo, stage. Or normal implantation may not occur.

Artificial fertilization also involves real risks to the mother. There is, for instance, the risk of infection. There is the risk of implantation of the embryo in the uterine cervix or in some other abnormal spot (ectopic pregnancy). There is the risk of abortion during the pregnancy. And, of course, there is always the risk of producing a malformed or defective infant.

For these reasons, some doctors and laymen have expressed reservations about the ethics of artificial fertilization. Steptoe and Edwards have been criticized for attempting the procedure, with its obvious risks, prior to more extensive animal studies. Finally, some have objected on religious grounds.

But other authorities see the procedure as simply a method for allowing a woman with absent or defective Fallopian tubes to bear a child.

"It's no more an ethical problem than is giving a hypothyroid patient thyroid hormone," says Andrews, citing another common cause of female sterility.

Most people, judging by the response to the English success, seem to concur. And the new process may have other medical benefits as well.

### Embryonic deep freeze.

Through artificial fertilization and embryo freezing and storage, it may someday be possible for couples to have children at the precise intervals they wish. This child spacing may be more than simply a convenience. It has been shown, for instance, that when women have children spaced too closely together, there is a higher risk of infant death. Better child spacing may alleviate this problem.

It is also known that older couples face a higher risk of certain genetic defects, such as mongolism, in their offspring. Artificial fertilization and embryo storage might also be used to permit an older couple to have an infant that they conceived while younger.

Artificial fertilization may also prove useful in eliminating certain sex-linked inherited diseases. Some diseases—hemophilia is an example—are carried by women; others are carried by men. In a couple where the wife is a known carrier, she could still give birth to a

normal infant, using another woman's egg that has been fertilized by her husband. This situation is analogous to artificial insemination of the woman by sperm from another man.

It is easy to imagine other, more bizarre applications of artificial fertilization. Someday a woman may volunteer to carry another woman's fetus and give birth to her baby. Such an arrangement might be useful in instances where a woman's uterus has been removed, although her ovaries are intact. By "borrowing" a womb from another female, such a woman could use the surrogate mother to bear her own child!

But for now such possibilities are more in the realm of science fiction than in that of medical care. The details of the methods used by Steptoe and Edwards have not yet even been disseminated to the medical community. It will take time before artificial fertilization is done in most hospitals, though major medical centers may be able to offer the service sooner.

Probably within a year or two, judges William Andrews, several centers will be offering artificial fertilization, at least on a limited basis.

But other experts disagree, citing the almost total absence of artificial-fertilization research, even in the largest medical centers.

### The research log-jam.

The lack of artificial-fertilization research, explains Bruce Young, head of Bellevue Hospital's high-risk pregnancy clinic, is due to a lack of federal support. A few years ago, as a result of pressure from right-to-life and other groups, the federal government placed a moratorium on funds for any kind of fetal research, including artificial fertilization. Many scientists, including Young, opposed the ban.

The moratorium was supposed to be only temporary, while the government set up a National Ethics Advisory Board, which could then decide which research efforts would be suitable for federal grants.

"The board was just formed in January," Young complains. "So far they've only had one meeting."

Young and other researchers fear that the halt in research support will drag on indefinitely. Fetal research, they point out, has been responsible for many remarkable discoveries, such as methods for the treatment of Rh disease. Such research, they feel, should be encouraged. Nevertheless, at present the government is still marking time pending the advisory board's decision, which does not appear imminent.

All this means it will be some time before artificial fertilization is made available to Americans. But one thing is certain: with the birth of Louise Brown, artificial fertilization left the realm of science fiction. It is now, clearly, an emerging therapeutic addition to medical care. The only question is how long it will be before would-be parents will benefit from this truly spectacular advance. ●