The finding of an apparently healthy infant dead in his crib is as big a shock to physicians as to the parents. Sudden infant death syndrome (SIDS) is a definite entity that cannot be predicted and, therefore, cannot be prevented. Commonly known as “crib death” or “cot death,” SIDS causes approximately 10,000 infant deaths each year in the United States. It is responsible for approximately three deaths of every 1,000 births. After the first week of life, SIDS is the most important single cause of death of infants under 1 year of age; it ranks second only to accidents as the greatest cause of death in children less than 15 years of age. It is more frequent in winter months, has a higher incidence in males and among lower socioeconomic groups, and has a peak incidence at 3 months of age. SIDS can be confirmed, but not explained, at autopsy by changes in the tissues of the respiratory system and the absence of other lethal lesions.

This statement was prepared to provide guidelines for the pediatrician for his contact with the family and the agencies in the community when SIDS occurs.

Because guilt feelings are usually associated with SIDS, the parents will need counsel and support to help alleviate these feelings, especially when they begin to wonder what they did wrong. The family should be encouraged to talk freely about their feelings, and they can be told about the usual reactions to losing a child. The counseling given initially may not be effective because of the emotional shock immediately following the infant’s death; therefore, the pediatrician should again meet with the family a day or two after the death.

Special attention should be given to the reaction of siblings, who also have characteristic grief reactions. They are not likely to express their feelings of loss and guilt unless encouraged to do so by their parents. The pediatrician should support parents in this difficult task and encourage them to be sensitive to unusual behavior patterns in siblings.

In most states cases of sudden infant death syndrome automatically become coroner’s cases, and autopsies are mandatory. Where this is not the case, permission for an autopsy should be encouraged to provide the parents with further reassurance that they were not responsible for the death. It may be necessary to assist parents in obtaining autopsies without cost. The pediatrician should meet with the family as soon as possible after the autopsy to discuss the findings and help relieve parental anxiety. Another meeting with the parents three to four months later will give the pediatrician an opportunity to see how the family is working through their grief. The pediatrician should assure the family of his availability and willingness to help.

The National Institute of Child Health and Human Development will soon undertake, with the aid of pediatric pathologists, development of a list of pathologic findings which must be ruled out as a cause of death before the death can be classified as SIDS. Clinical diagnosis such as aspiration pneumonia, suffocation, tracheobronchitis, or status thymicolymphaticus should not be made unless there is adequate autopsy evidence that these conditions were present. SIDS is often equated with child abuse by local agencies, and this practice should be condemned. The parents need compassion and consolation, not the cruel and inhumane treatment some local authorities give them. The pediatrician should work with the local medical examiners or coroners and with law enforcement agencies to prevent unethical or crude approaches to the parents about the reason for their child’s death.

* Physicians and parents may obtain additional information and assistance from the National Foundation for Sudden Infant Death, Inc., 1501 Broadway, New York, New York 10036, and The International Guild for Infant Survival, Inc., 6822 Brompton Road, Baltimore, Maryland 21207.

The statements presented herein do not preclude alternatives which may be more appropriate, taking into account local situations and all other relevant facts.
Many families who lose an infant because of SIDS do not have a personal physician. Pediatricians should be aware of parental anxiety and offer anticipatory guidance. The counseling services of local health departments or other agencies should be made available to them. Preventive psychiatry is also vital in avoiding future problems, including whether or not the parents should have more children.

Pediatricians should work toward community understanding about SIDS. They may offer advice and support to local parent groups who assist other families. State chapters should identify and establish liaison with the principal parent groups and become more actively involved in the activities in the state, especially in public education programs regarding SIDS.

A resolution is now pending before Congress to provide programs for SIDS and to assign a high priority to SIDS education and research at the National Institute of Child Health and Human Development. It also calls for the Department of Health, Education, and Welfare to develop services required by families who lose infants because of SIDS. Programs to assist those conducting research on SIDS and those encountering it in practice would also be developed.

Research in SIDS is continuously being undertaken. Pediatricians are encouraged to become aware of the results of this research as they are reported in the literature.

COMMITTEE ON INFANT AND PRESCHOOL CHILD
WILLIAM B. FORSYTH, M.D. Chairman
JOHN E. ALLEN, M.D.
JOSEPH W. BRINKLEY, M.D.
ALICE D. CHENOWETH, M. D.
GERTRUDE HUNTER, M.D.
ROLAND E. MILLER, M.D.
A. FREDERICK NORTH, JR., M.D.
PATRICIA T. SCHLOSSER, M.D.∗
EARL SIEGEL, M.D.
MARBODEN G. WAGNER, M.D.∗

Liaison representatives:
ROWLAND L. MINDLIN, M.D.,
American Public Health Association

ROBERT J. CLAYTON, M.D.,
Project Head Start

Consultants:
DAVID B. FRIEDMAN, M.D.
ANN DeHUFF PETERS, M.D.

BIBLIOGRAPHY
The Facts on Sudden Infant Death (pamphlet suitable for parents). The International Guild for Infant Survival, Inc., 6822 Brompton Road, Baltimore, Maryland 21207.
See also the Announcement:
The Sudden Infant Death Syndrome: Expanded Research Program.
THE SUDDEN INFANT DEATH SYNDROME
William B. Forsyth, John E. Allen, Joseph W. Brinkley, Alice D. Chenoweth, Gertrude Hunter, Roland E. Miller, A. Frederick North, Jr, Patricia T. Schloesser, Earl Siegel, Marsden G. Wagner, Rowland L. Mindlin, Robert J. Clayton, David B. Friedman and Ann DeHuff Peters
Pediatrics 1972;50;964

Updated Information & Services
including high resolution figures, can be found at:
http://pediatrics.aappublications.org/content/50/6/964

Permissions & Licensing
Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
http://www.aappublications.org/site/misc/Permissions.xhtml

Reprints
Information about ordering reprints can be found online:
http://www.aappublications.org/site/misc/reprints.xhtml
THE SUDDEN INFANT DEATH SYNDROME
William B. Forsyth, John E. Allen, Joseph W. Brinkley, Alice D. Chenoweth, Gertrude Hunter, Roland E. Miller, A. Frederick North, Jr, Patricia T. Schloesser, Earl Siegel, Marsden G. Wagner, Rowland L. Mindlin, Robert J. Clayton, David B. Friedman and Ann DeHuff Peters

Pediatrics 1972;50:964

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/50/6/964