Infant colic:

when "it will pass" is not an answer

What you were told

Your baby cries for hours after feeds. They arch their back, contract, writhe, won't sleep. You seek advice. You are told: infant colic, it's normal, it will pass around 3 months. You are looked at sometimes with kindness, sometimes with faint impatience. You leave without an explanation, without treatment, and with the vague feeling that you are either too anxious or not patient enough.

“ What you experienced was not in your head. And 'it will pass' is not a diagnosis. ”

'Functional': a closure, not an explanation

In medicine, 'functional' means: real symptom, cause not identified with current tools. It does not mean 'without cause' — it means 'uninvestigated cause'. So-called functional colic affects 20 to 40% of newborns. This rate should prompt questions: if it were as high in adults, a common mechanism would be sought. In infants, it is normalised.

Spontaneous resolution around 3 months does not prove the absence of biological consequence. It proves that the baby stopped crying. These are not the same thing. An immature organism that learns its distress signals produce no adequate response is not healed — it has adapted. This adaptation process carries a documented neurobiological cost on the HPA axis, mast cell reactivity, and amygdala calibration.

What the PMCHS terrain explains

Within the PMCHS framework, persistent post-prandial colic may represent non-IgE intestinal mast cell activation — that is, without identifiable classical allergy. The mast cells of the infant's digestive mucosa, on a PMCHS terrain inherited from the maternal line, present a lowered degranulation threshold. Food ingestion — direct in bottle-fed infants, mediated through breast milk in breastfed infants — may trigger local release of histamine, prostaglandins and leukotrienes, producing visceral pain, hypermotility and intestinal hyperpermeability.

This mechanism is not hypothetical: the high mast cell density in the infant gut is documented, mast cell-vagal nerve fibre coupling is established, and non-IgE post-prandial mast cell activation is described in MCAS literature. What is absent is the clinical willingness to measure it in infants presenting this picture.

Tools exist — they are not used

Infant pain is measurable. Validated scales exist (PIPP-R, NIPS), autonomous markers are accessible (heart rate variability, NIPE device), and non-invasive urinary biomarkers could objectively document mast cell

activation: urinary N-methyl-histamine, LTE4, PGD2, salivary cortisol. None of these tools is used in routine colic assessment — not because they are unavailable, but because using them would challenge the category of 'functional'.

“ The newborn is the most vulnerable non-verbal patient that exists. Medical standards require pain assessment for all non-verbal patients. Colic constitutes the only systematic exception. This is not a scientific limitation — it is a choice. ”

The link to the maternal PMCHS terrain

In our survey (N=423), 9.7% of respondents report a family history of sudden infant death syndrome (SIDS) — far exceeding the general population prevalence of approximately 0.05%. These respondents present a mast cell hyperreactivity terrain transmitted predominantly along the maternal line (ratio 5.4:1). Gold et al. (2000) demonstrated that 73% of living family members from SIDS-affected families present heritable mast cell hyper-releasability.

An infant whose mother carries a PMCHS terrain is exposed to two cumulative factors: an inherited terrain lowering the mast cell degranulation threshold, and perinatal exposure to maternal stress that further programmes the HPA axis. Persistent colic in this context is not a sign of immaturity or temperament — it may be the first visible signal of a programmed mast cell terrain.

What you can observe and ask for

- **Keep a precise diary**: time of crying, duration, relationship to feeds, mother's foods (if breastfeeding). A systematic post-prandial pattern is a clinical signal, not a coincidence.
- **If breastfeeding**: try to identify whether certain foods you eat (fermented foods, tomatoes, alcohol, spices, histamine-rich foods) precede episodes. Breast milk transmits food mediators.
- **Ask for a urinary histamine test** for yourself if you suspect a PMCHS/MCAS terrain — it is the most accessible measurement. It is not standard but it exists.
- **Mention all family history**: SIDS, MCAS, lipedema, PCOS, hEDS, ADHD, ASD — this information has clinical value for guiding management.
- **You are not a hypochondriac**. A baby who cries for hours after every feed is suffering. Whether measurable or not, that suffering deserves a response.

Note: This note is an information tool, not a medical prescription. If your infant has intense and persistent crying, consult your paediatrician. In case of signs of severe allergy, seek emergency care.