Letters to the Editor

Pediatric Health Screening

To the Editor:

The article by Eggertsen et al, "An Updated Protocol for Pediatric Health Screening," *(Eggertsen SC, Schneeweiss R, Bergman JJ. J Fam Pract 10:25, 1980),* is in general an excellent analysis of pediatric screening. However, I would like to take issue with two points.

First, the authors point out that we do not even know how to define pediatric hypertension much less what to do with it if we find it. Hypertension, defined by adult standards, is rare under age ten but rises in incidence during adolescence and presumably carries with it risk of significant morbidity.[1] In support of screening for hypertension at ages 4 and 6, the authors cite "authorities," not evidence. I contend screening for hypertension should be category III in children under age 10 and should be category I in adolescents. I would be most interested in hearing of evidence to support screening for hypertension in younger children.

Secondly, although the authors mention screening for several conditions by specific parts of the physical examination, eg, cardiac ascultation and tests for strabismus, no specific mention is made in the article of screening for congenital hip dislocation; (it does appear on one of the flow sheets, Figure 1). This disease is common (incidence between 1 in 400 to 2,000 children), asymptomatic, and easily detected. If treated early, it is usually curable. If undetected, it leads to serious morbidity. Screening for congenital hip dislocation should be included several times in the first six months of life as a category I procedure.

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References

1. Lauer RM, Connor WE, Leaverton PE, et al: Coronary heart disease risk factors in school children: The Muscatine study. J Pediatr 85:697, 1975

To the Editor:

Drs. Eggertsen, Schneeweiss, and Bergman's recent article in January, "An Updated Protocol for Pediatric Health Screening" (*J Fam Pract* 10:25, 1980), is an excellent attempt at rational preventive care. However, I was quite dismayed at one glaring omission. De-

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Table 1. Supplemental Fluoride Dosage Schedule (mg/day†)

Age	Concentration of Fluoride in Drinking Water (ppm)		
	<0.3	0.3-0.7	>0.7
2 weeks–2 years	0.25	0	0
2–3 years	0.50	0.25	0
3–16 years	1.00	0.50	0

†2.2 mg sodium fluoride contains 1 mg fluoride
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spite the unequivocal evidence favoring fluoride supplementation as prevention of dental caries, there is no mention of this in their protocol. Even though most cities now have fluoridated water supplies, a large segment of our practice in the rural Upper Peninsula of Michigan obtains its water supply from wells with little or no natural fluoride. Since oral fluoride supplementation can lead to a 50 percent decrease in the number of dental caries, it is essential that these children do receive oral fluoride supplements. The dosage schedule approved by the Committee on Nutrition of the American Academy of Pediatrics is listed in Table 1.

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Greater awareness by family physicians of the need for fluoride supplementation would greatly reduce the time and expense our children will spend in one of our own least favorite spots—the dentist's chair.

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The preceding letters were referred to Drs. Schneeweiss, Eggertsen, and Bergman who respond as follows:

Dr. Frame's thoughtful letter touches on the controversies surrounding the area of health screening and is exactly the kind of response we hoped to elicit with our article.

At this time evidence does not exist in support of screening for hypertension in the pediatric age group. However, on the other hand, there is no evidence to the converse. For that reason we have chosen to put hypertension screening in Category II (uncertain benefit) and hope that future studies will elucidate this point.

The issue of cost-benefit including the risks and cost of working-up false-positive cases will have to be addressed.

Dr. Frame has appropriately pointed out the importance of examining carefully for congenital dislocation of the hip and it is indeed a specific part of the recommended physical examination as implied in Figures 3 and 4. We absolutely endorse the routine but careful exclusion of this problem by repeated examinations in the first year of life.

Dr. Hickner's point regarding the significance of fluoride supplementation in the prevention of dental caries, in those areas where the water supply is unfluoridated, is well taken. It is chastening to note that we ourselves had overlooked this issue since we work in a city where water supplies are fluoridated!

As the Committee on Nutrition of the American Academy of Pediatrics has indicated, there remains some controversy regarding the optimum ages for fluoride supplementation.[1] Some physicians do not initiate treatment under the age of six months to reduce problems with mild fluorosis. In addition, the development of the permanent tooth crowns, excluding the third molar, which is more variable, is complete by ages 10-12 years. It is not clear whether there is benefit in continuing with fluoride supplements beyond this age.

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Reference

1. American Academy of Pediatrics: Fluoride supplementation: Revised dosage schedule. Pediatrics 63:150, 1979