LETTERS TO THE EDITOR

The Journal welcomes Letters to the Editor. If found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with Journal style.

FEBRILE SEIZURES

To the Editor:

I would like to react to the publication of the paper by Mary Sollinger Applegate and Warren Lo: "Febrile Seizures: Current Concepts Concerning Prognosis and Clinical Management" (*J Fam Pract 1989; 29:422–428*). They pose that the peak incidence of febrile seizures in both sexes is at 23.3 months, referring to a study of Nelson and Ellenberg.[1] The latter, however, wrote that "the average age at onset of febrile seizures was 23.3 months." As far as I know, the peak incidence of these features is not the same as the average age at which they occur. Furthermore, Applegate and Lo suggest that the peak incidence of febrile convulsions in boys and in girls occurs at exactly the same age.

I would think that results of a former study have been misinterpreted.

Marijke E. Verburgh
Department of Family Practice
Erasmus Universiteit, Rotterdam

Reference

1. Nelson KB, Ellenberg JH: Predictors of epilepsy in children who have experienced febrile seizures. N Engl J Med 1976; 295: 1029–1033

The preceding letter was referred to Drs Applegate and Lo, who respond as follows:

We thank Dr Verburgh for pointing out that the "average age of onset" is different from the age of peak incidence for febrile seizures. We cited Drs Nelson and Ellenberg in error, and we stand corrected. We should point out that in this case the difference is inconsequential and does not misrepresent the literature. The Bristol study of 13,038 children with febrile seizures[1] found that 18.3% of the children had their first febrile seizure during the first year of life, 49.6% during the second year of life, and 21.4% during the third year of life. Thus, the "peak incidence" of febrile seizures occurs during the second year of life.

The other issue Dr Verburgh raises is whether the peak incidence of febrile seizures occurs at the same age in boys and girls. Nelson and Ellenberg reported in a second study that the "average age of onset of febrile seizures was 23.3 months for girls and 23.2 months for boys."[2] While the large numbers of children involved may render this difference *statistically* significant, for all *practical* purposes we do not consider this a major difference.

We believe that the original points of our review remain correct although we erred in our citation. We hope that this letter has clarified any misunderstandings.

Mary Sollinger Applegate, MD
Warren Lo, MD
Department of Pediatrics
The Ohio State University, Columbus

References

1. Verity CM, Butler NR, Golding J: Febrile convulsions in a national cohort followed up from birth. I: Prevalence and recurrence in the first five years of life. Br Med J 1985; 290:1307–1310
2. Nelson KB, Ellenberg JH: Prognosis in children with febrile seizures. Pediatrics 1978; 61:720–727

EARLY TOILET TRAINING

To the Editor:

I was interested to read the article by Dr Seim on toilet training in children.[1] There is a widely held view in the United States that a child must

Continued on page 360

Continued from page 262

be both psychologically and physiologically "mature" before successful toilet training can occur. As noted by Dr Seim, there has been almost no research to document these theories. They are no doubt nonsensical to much of the world where "potty training" begins shortly after birth.

I learned this shortly after the birth of my first child. My wife is from Pakistan and her mother, who lives with us, started to train my daughter at 2 weeks of age. This consisted of taking the child after each feeding and following each nap and holding her over the sink. My mother-in-law made a "spss" sound, which oriented my newborn daughter to the task at hand. By 3 months of age she obviously understood the association of the time, sound, and body position with voiding and defecation. By 1 year of age she was out of diapers both during the day and at night.

"Early" potty training is normal child development in India, Africa, and many parts of Asia. People from these countries find the "modern" practices of potty training in the West to be primitive and unsanitary. Imagine teaching a 2-year-old that a wet or dirty diaper is an acceptable thing to wear!

I have found many people who are concerned that early potty training will produce psychological trauma. I can only speculate that this stems from attempts to use negative reinforcement with 18-month-old children who have had no prior conditioning. This is certainly not the case for the millions of children around the world who are trained in the first year of life.

I have talked to several new mothers in my practice about early potty training. It has been successful with them only when there is consistency of the child's supervision during the first year of life. The child in day care is not a good candidate.

By 2 years of age we expect children to have mastered running, speaking, and a variety of social skills. It is amazing that we continue to feel that such children are often not old enough to control a couple of sphincter muscles!

Paul Fischer, MD
Department of Family Medicine
The Medical College of Georgia, Augusta

Reference

1. Seim HC: Toilet training in first children. J Fam Pract 1989; 29:633–636

TREATMENT OF HEMORRHOIDS

To the Editor:

An effective nonsurgical treatment for hemorrhoids was developed and introduced in Great Britain in 1965. Known as the Lord Procedure, for Peter Lord, former Secretary of the Royal College of Surgeons, this technique makes hemorrhoidectomy virtually obsolete for third-degree hemorrhoids.[1] Yet this successful technique, which avoids one of the most painful operations known, has remained unavailable in the United States for over 20 years.

The anus has three specialized highly vascular cushions that engorge to effectively close off the anal orifice. During normal defecation, the cushions, emptied of blood, permit easy passage of stool. In response to constipation and hard bulky stools, straining occurs. When the intrarectal pressure becomes greater than the venous pressure, engorgement of the cushions occurs when they should be empty, and the cushions are pushed out of the anal canal, during defecation, as hemorrhoids.[2] Over time, a narrowing of the canal occurs, probably as a response to the need to close the anus without benefit of the cushions.

Dr Lord's treatment consists of a single firm dilatation of the anus under general anesthesia. Knowing precisely how much to stretch the tissue determines the success rate. Afterward, the patient is comfortable. The hemorrhoids gradually return to their original site. Urinary retention and fecal impaction are unknown. Patients with recurrence after previous hemorrhoidectomy are especially grateful to avoid a second operation.

It is my firm conviction that the Lord Procedure should be available to family physicians. Questions and comments are welcome.

George C. Denniston, MD, MPH
Department of Family Medicine
University of Washington, Seattle

References

1. Lord PH: A day-case procedure for the cure of third-degree haemorrhoids. Br J Surg 1969; 56:747–749
2. Thomson WHF: The nature of haemorrhoids. Br J Surg 1975; 62:542–552

CORRECTION

The letter recently published in the *Journal* (*Replogle WH, Eicke FJ: Significance of multiple inferential tests. J Fam Pract 1990; 30(1): 15*) contains a typographical error that may be misleading to your readership. The second sentence of the third paragraph should read "$(1 - .95^{16})$" as opposed to "(1 to .95)."

W. H. Replogle, PhD
Department of Family Medicine
University of Mississippi Medical Center, Jackson