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AAP News, *the official newspaper of the American Academy of Pediatrics, is dedicated to informing, educating and inspiring readers on matters related to pediatric health care.*

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Second Opinions

Tap-water sterilization

The lead article in the November *AAP News*, "Tap-water supply safety questioned," appropriately acknowledges the lack of consensus between formula manufacturers, pediatricians and public-health officials on the propriety of routinely sterilizing water for infant-formula preparation. Yet, as the article proceeds, only advocates of sterilization are quoted and the article takes on a decidedly pro-sterilization slant.

The impetus for this "wake up call" is the 1993 cryptosporidium outbreak in Milwaukee. Yet, the data from that outbreak could just as well prompt a call to relax infant-formula preparation standards. Nearly all of the deaths from that outbreak affected immunosuppressed hosts. There were no fatalities among healthy infants, and in fact, the overall risk of illness was lowest between ages 0-10 and over age 70 (*New England Journal of Medicine* 1994; 331: 161-167).

As pointed out in the *AAP News* article, the U.S. Centers for Disease Control and Prevention now recommends that drinking water be sterilized for immunocompromized patients of all ages, a position presumably based on the Milwaukee experience.

In any cost-benefit analysis of infant-formula preparation standards today, the environmental costs need to be factored in. This was not the case in the prerefrigeration era when sterilization policies were first formulated. How many BTUs of energy from nonrenewable fuels would be consumed by routine sterilization of water to prepare formula, and what would be the contribution to the greenhouse effect? Would these costs be offset by the hypothetical benefits?

The *AAP News* article's emphasis on knowledge of local water quality issues is a point well-taken. I've practiced in both urban and rural areas during the past 30 years and have never advocated water sterilization for infant-formula preparation, unless dealing with untested or unsanitary well water. This approach has served me well, although admittedly cryptosporidium puts a new twist on the issue. Still, it is clear that person-to-person spread of enteric pathogens dwarfs contaminated drinking water as a U.S. public-health issue, with food contamination playing an intermediate role.

John F. Hick, M.D, FAAP
St. Paul, MN

Speculum positioning

[☎] In the *Second Opinions* section of the November *AAP News*, Dr. Fred Weinberg discussed the incorrect positioning of the otoscopic speculum seen in advertisements and, I might add, on TV. I found his solution, that is the upside-down technique, clumsy for me. I suggest that the examiner use the otoscope right side up, as ergonomically designed, while placing the index finger alongside the speculum so that the fingertip is about the same distance as the end of the speculum. Meanwhile, the examiner should use his middle finger to brace and support the speculum against the child's head. This technique prevents accidents and frees the other hand for maneuvering the ear in proper position and controlling head movement.

Roy Halpern, M.D., FAAP
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Growth-chart plotting

The view expressed by Dr. William Rogers ("Growth chart concern of shrinking importance," *Second Opinions*, October *AAP News*) reiterates my concern for definitive AAP guidelines on growth-chart plotting.

There are those pediatricians who do not feel the need to chart growth. Dr. Rogers refers to this exercise as a "medical school learning procedure."

Former medical students Drs. Nelson and Rudolph (of textbook fame) would disagree with this assessment. Accurate growth data measurement and plotting are as basic to well-child care as checking vital signs or examining a child's ears or heart.

Many pediatricians wait to refer patients who have "suspiciously abnormal" findings. In many conditions, such as inflammatory bowel disease, growth hormone deficiency, acquired hypothyroidism, Turner's syndrome mosaicism and gluten-sensitive enteropathy, to name just a few, growth failure may be the only abnormal finding! In these conditions, only careful attention to accurate measurement and plotting would detect growth failure at an early age.

It is time to stop the short-sightedness of "eyeballing" and advocate growth-plotting as a pillar of well-child care.

Samuel M. Freedman, M.D., FAAP
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Pre-existing conditions

Alert! Alert! Does the AAP membership realize that the insurance company with which we have contracted to provide all our members' needs does not insure persons with diabetes type I?

Our Academy health insurance refused to cover my child because he has diabetes! Most insurances will require a one-year waiting period for a pre-existing condition, but they didn't even offer that. How ironic! Will those persons at the Academy who are in charge of the insurance section please act on this?

Patricia V. Rossi, M.D., FAAP
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Pediatric Insurance Consultants Inc. responds: To include applicants who are in necessary treatment would increase our rates and drive out the healthy risk. Our rates contemplate "unknown" health conditions and accidents. Group association plans like the AAP plan are "voluntary." Members may apply at any time, but are subject to underwriting. This requirement evens the spread of risk of the insurer who can offer a competitive rate.

Filter-paper lead tests

I am very surprised to read the article, "Filter-paper lead tests labeled unreliable" (November *AAP News*). This article is based exclusively on hearsay. There is no scientific evidence whatsoever to support its statements.

Both filter-paper or capillary-tube collection techniques are subject to the risk of contamination with ubiquitous lead and hence subject to "false positives." Available studies clearly indicate, however, that there is no difference in this respect between the two types of tests. The filter-paper test is, thus, as reliable as the capillary-tube test. Both tests, of course, require impeccable technique to minimize false positives.

The U.S. Centers for Disease Control and Prevention (CDC) has not, and cannot, condemn this type of test. At the last meeting of the CDC Committee on Childhood Lead Poisoning in October, the excellent results obtained with this technique in the Salt Lake area were presented by one of its most respected members, Dr. Thomas Schlenker.

I am a member of the CDC committee on lead poisoning. My contribution to that field is in the record. The filter-paper technique was developed by B. Davidow at the New York City Bureau of Laboratories together with us (*Ann Clin Liab Sci*: 6:209, 1976). My laboratory has confirmed through the years the filter-paper test's validity through blind testing for lead of samples analyzed elsewhere by this technique, for quality control. Our own studies of the Himalyan population (*Science*:210:1135, 1980) included measurements of extremely low levels of lead on filter paper.

I have no personal interest whatsoever in the commercial application of this technique.

Your categorical and misinformed article unnecessarily criticizes a viable technique that has been used successfully in hundreds of thousands of children. I believe that, in fairness, you owe a retraction of your article, which damages those children who may not be screened because of it, and also unjustly slights the manufacturers of testing kits.

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Unjust condemnation

The article by Annette Spence ("Filter-paper tests labeled unreliable," November *AAP News*) unjustly condemns the only nontraumatic and inexpensive lead screening test currently available in the United States. The views expressed in the