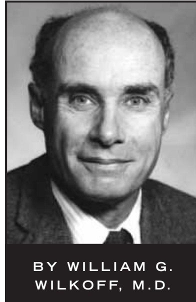
LETTERS FROM MAINE

Riding Shotgun

Research that agrees with my anecdotal observations and supports my nonconforming practices always warms my heart, so the lead article in the December issue of Pediatrics really got my old cockles cooking.



BY WILLIAM G. WILKOFF, M.D.

After carefully evaluating 42 preventive interventions recommended by at least two national organizations concerned with child health, the investigators concluded that "limited direct evidence was found to support" these recommendations. So many interventions have been recommended and mandated, they also observed, that implementation of an unsupported recommendation by pediatricians could actually be harmful because it may displace "other beneficial activities" (Pediatrics 2004;114:1511-21).

What a bold and long overdue observation. Over the past 30 years, well-meaning groups from every nook and cranny of the child-oriented world have recommended that we pediatricians invest our hard-earned reputations and precious time promoting their pet ventures. It's time for us to say, "Whoa! Let's see if what you're asking us to do works."

Even if the majority of these recommendations were well supported, their overwhelming volume would make implementation impossible even by the most efficient practitioner. When unproven interventions become mandated by state laws and regulations, those of us who dare to ignore them are vulnerable to financial penalties and, even worse, professional censure.

Obviously, this situation represents a serious challenge to our profession. We must demand that, regardless how valid they sound, all recommended interventions be evidence based.

Good research takes time, though, particularly when some of the outcomes may not be measurable until our patients reach adulthood. So what should we front-liners do for the next few decades while the researchers are gathering the evidence?

We must change our attitude toward well-child care. Health maintenance visits should be parent- and patient-driven. For too long, we and the committees that coach us have been writing the agendas for these visits.

This paternalistic attitude ignores the basic truth that our patients and their parents know best what is troubling them. Occasionally, we may need to help them articulate and focus their concerns, but it is the families and not the committees that should be writing the script for well-child visits. It's time for us to slide out from behind the steering wheel and begin riding shotgun. From our new seat on the passenger's side, we must keep our eyes on the road ahead and be prepared to warn parents when we see potholes in the path they have chosen.

We must replace our committee-driven interventions with open-ended questions that signal to parents that we are concerned about what concerns them. Then we must patiently wait for their answers. Instead of asking every family if they keep a gun in the house, we must become experts at reading body language and listening to the answers of simple questions like, "How are things going? Is your baby happy? Are you happy?" Dialogues that build on these open-ended questions will create the framework of a more valuable well-child visit.

If the parent is experienced and voices no concerns when offered the opportunity to express them, the visit may last just long enough for a good exam (though we may even find that part unnecessary) and some immunizations.

On the other hand, our apparent willingness to listen may encourage the depressed mother of a toddler to share her secret that she has been abusing the child. A well-child visit cannot be a one-size-fits-all event fabricated from a collection of committee-made parts.

We must acknowledge that the most important component of well-child care doesn't occur during the health maintenance visit. The three critical elements in keeping a child healthy are availability, availability, and availability. Parents already believe that pediatricians know a lot about children. Our challenge is to demonstrate that we care about their concerns and are eager to answer their questions not just at well-child visits, but at any time. An illness can be an excellent opportunity to get to know more about the patient and his family and to make it clear that we are good and concerned listeners.

It sounds like the medical home is the answer again. ■

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LETTERS

Pain Relief in Circumcision

I am not surprised by the findings of Praveen Kumar, M.D., of reluctance on the part of physicians to use adequate analgesia during circumcision ("Raise Awareness of Pain Relief Options in Infant Circumcision," November 2004, p. 2).

My experience at the community hospital level revealed that there is a belief among physicians that topical cream works as well as the dorsal penile nerve block or ring anesthesia.

Physicians who lack training and experience in the administration of these options will become overnight converts once they witness their efficacy.

New physicians have to be proctored at our institution before getting approval for doing circumcision. To my dismay, as I proctored a new colleague, I saw that nurses applied lidocaine cream topically per the physician's instructions.

I suggested that a dorsal penile nerve block might be more effective, and the procedure went smoothly. (I routinely use powdered sugar–coated pacifiers during the procedure.) Well, I have a convert! That physician has changed the practice from topical to penile block because an impressive analgesia was demonstrated.

Long ago, the Journal of the American Medical Association published a study proving that topical anesthetics are ineffective. Common sense must dictate that no topical would penetrate the part of skin attached to the glans and the surface of the glans.

I propose a change in our circumcision ritual if we want to use topical agents, and that is to wait until the natural separation of foreskin, which takes place at around 2-4 years of age. I predict that by applying topical agent on the outside as well as on the underside of the prepuce, we will attain adequate analgesia. These agents could be used in situations where circumcision is done at an older age for religious reasons.

In my experience, removing skin lesions after applying topical agents has been unsuccessful in terms of adequate analgesia; it might not be as effective as the penile block.

On the behalf of all the male newborns in this country, I beg physicians to be humane to the most vulnerable and voiceless (aside from the crying) segment of society. How many of these physicians would consider a dental—or any—procedure without adequate analgesia?

Amar Dave, M.D.
Ottawa, Ill.

Will HPV Vaccine Backfire?

While I congratulate those who have developed a vaccine that is very effective in preventing the development of cervical dysplasia by human papillomavirus strain 16—purely because of the work and expertise involved—I can't help but think that we are winning the battle but losing the war ("Experimental Vaccine Prevents HPV 16–Associated Cervical Ca," December 2004, p. 10).

If you think really seriously about this, we offer potential solutions for HPV, but we know that we cannot guarantee protection from all STDs.

I predict that once an HPV vaccine is released, large numbers of women (and men) will come in for injections, especially if it is promoted through direct-to-consumer advertising. I also believe that unless we are very careful, these patients will consider themselves able to continue unhealthy sexual behavior (more than one lifetime partner), or will feel they can take more risks. This will potentially lead to increases in other STDs in the same patients we believe we are trying to protect!

The science and ingenuity required to put these vaccines together is fantastic. But when will we all—physicians, researchers, and the public—realize that we need to prevent putting ourselves into harm's way by not doing dangerous things? During a time when I don't believe any parents want to send their children to be potential casualties in the war in Iraq, how is it that we can send a message that potentially makes people feel impervious to STDs?

Jerome A. Klobutcher, M.D.
Des Plaines, Ill.

Candidemia Clarification

I am writing to provide some clarification to the article, "Candidemia Deaths Are Relatively Low" (July 2004, p. 22).

Essentially, our study assessed the increased risk of mortality and excess length of hospital stay experienced by hospitalized children with candidemia. Because this infection often occurs in children whose health is already weakened by an underlying medical condition, we used a multivariable, matched analysis to eliminate the effects of these conditions and identify the independent effect of candidemia on the outcomes.

We concluded that children with candidemia experienced a 10% increased risk of mortality and approximately 23 extra days in the hospital, *compared with children without candidemia who were similar in many other observed characteristics such as age, gender, receipt of clinical procedures, and underlying chronic conditions,* not "compared with children hospitalized for other reasons," as stated in the article.

The article also incorrectly notes that clinicians should consider candidemia as a condition that occurs in healthy children. Although a substantial proportion of candidemia cases (37%) were not in the typically high-risk neonatal, cancer, and solid organ transplant populations, we found that 47% of the children who did not present in these groups had a concurrent complex medical condition such as a chronic gastrointestinal illness or a congenital cardiovascular condition, and a greater proportion received a clinical procedure such as vascular catheterization, indicating that they were not otherwise healthy.

In addition, the article's title suggests that candidemia does not pose a serious threat among hospitalized children. Despite finding a lower attributable mortality than prior retrospective studies, we assert that a 10% increased risk of mortality solely due to candidemia is substantial and warrants further research toward preventing adverse outcomes caused by this infection. In fact, our additional analysis showed that the excess length of stay caused by candidemia was almost twofold greater among children than adults.

Jaclyn Chu
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