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.

PRENATAL FLUORIDE SUPPLEMENTATION

To the Editor:

Rigilano, Friedler, and Ehemann *(Rigilano JC, Friedler EM, Ehemann LJ: Fluoride prescribing patterns among primary care physicians. J Fam Pract 1985; 21:381-385)* study an important preventable health problem. The authors establish that current practices of postnatal fluoride supplementation are erratic. They propose routine recommendation of prenatal fluoride supplementation.

Although the value of fluoride supplementation for infants and children is proven and well-accepted, prenatal fluoride supplementation remains controversial. Rigilano et al base their recommendation for prenatal fluoride supplementation on a study by Glenn et al, which has serious flaws.[1] It is retrospective, and treatment and control groups were poorly matched. The children whose mothers had taken prenatal fluoride were younger (mean age 5.2 years) than their untreated controls (mean age 9.0 years), and therefore had less time to develop caries. Because the mean age of treated children was 5.2 years, little can be said about their future permanent teeth. Children exposed to prenatal fluoride were more often third and fourth children, while the untreated children were more often second- and firstborns. The mothers were older when carrying the treated children than when pregnant with the control children. Importantly, Glenn et al discuss neither how women were selected for prenatal fluoride supplementation nor how women were selected for no treatment. The women who accepted prenatal fluoride supplementation may have been more likely to ensure good brushing and dietary habits as well as compliance with postnatal fluoride supplementation than the untreated controls. Numerous other factors were not controlled for or examined: the amount of prenatal consumption of fluoridated water and calcium by mothers, mothers' compliance with prenatal fluoride supplements, the children's dietary and brushing habits, and the children's compliance with fluoride supplements. Finally, safety of prenatal fluoride supplementation is hardly proven with only 117 treated women. Before prenatal fluoride supplementation is recommended for routine care, prospective studies should prove its safety and efficacy.

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Reference

1. Glenn FB, Glenn WD, Duncan RC: Fluoride tablet supplementation during pregnancy for caries immunity. A study of the offspring produced. Am J Obstet Gynecol 1982; 143:560-564

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The preceding letter was referred to Drs. Rigilano, Friedler, and Ehemann, who respond as follows:

We appreciate Dr. Hamilton's comments on the issue of prenatal fluoride, and we agree that the study by Glenn et al has certain flaws. We stated in our article: "There is no question that further prospective studies on the use of prenatal fluoride are needed." We maintain, however, that while efficacy remains controversial, the safety of prenatal fluoride is not an issue, as it has been widely used for many years in Europe, Canada, and Australia, and no ill effects have been observed. Additionally, there are many regions in the United States where the natural fluoride content of the water delivers a considerably higher dose of fluoride per day without ill effects on the fetus having been noted. The Food and Drug Administration recognizes fluoride as being safe for use in pregnancy.

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GRADED EXERCISE TESTING

To the Editor:

I am pleased to see articles on experiences of family physicians performing procedures as found in the Zoller and Boyd article on graded exercise testing in a family practice office *(Zoller DP, Boyd GE: Six-year experience with graded exercise testing in a model family practice office. J Fam Pract 1985; 21:451-454)*. However, this article should have contained more comparison to the known literature on the rate of complications of the procedure. The article notes that there were two patients of the 275 receiving the test with complications; one required emergency bypass surgery and another had a myocardial infarction. This rate is equivalent to 72.7 complications per 10,000 tests. One large study of 518,448 exercise stress tests had a complication rate of 8.86 per 10,000 tests and 3.58 myocardial infarctions per 10,000 tests.[1]

The higher rate of complication in the family practice office is discomforting. In doing an exercise stress test, one of the important aspects is knowing when to stop the test. If the patient is pushed too hard, there is likely to be a higher rate of complications. This theory as to why there may have been an unusually high rate of complications could also explain the low rate of false-negative studies. If the tests were not stopped soon enough, there would be a lower rate of false-negative studies.

With only two complications, it is difficult to tell whether the difference between this study and national figures is real and meaningful. However, there are clearly negative consequences, and further follow-up after more tests have been done is necessary.

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Reference

1. Stuart RJ, Ellestad MH: National survey of exercise stress testing facilities. Chest 1980; 77:94-97