ings from lower costs for terminal care. All these factors contribute to the cost of $52,241 per year of life saved.

Although endometrial cancer is more common in older women, it is still an uncommon disease. Dr Senter suggests using the bimanual examination as a screening technique. Koss and colleagues screened a cohort of 2,586 asymptomatic women for endometrial cancer over a 3½-year period (68% of the women underwent more than one screening). All women underwent direct endometrial biopsy and bimanual pelvic examination. Overall, 17 cases of occult uterine carcinoma were detected. Of these, only 2 had enlarged uteri.[3] Thus, in this cohort the sensitivity of screening asymptomatic women for endometrial cancer using bimanual examination was only 12%. A test with a sensitivity of only 12% is not appropriate for use in mass screening. Because 80% of women with endometrial cancer present with abnormal bleeding, however, teaching women to report postmenopausal bleeding is an important preventive strategy.[2]

Certainly decisions about screening for cancer in the elderly should be individualized, and clinicians must weigh the risks and benefits for each patient. Routine screening, however, for rare diseases using screening tests that have low sensitivities may not be the most prudent use of preventive resources.

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Exaggerated Threat of Childhood Lead Poisoning in California—Epidemic by Edict

To THE EDITOR: California children were previously considered to be at low risk for lead poisoning compared with children in Eastern states such as Massachusetts and Maryland, where old, deteriorated housing with leaded paint is presumably more common. In 1989 the California Department of Health Services (CDHS) reported on blood lead levels in infants and children younger than 6 years living in Oakland and Los Angeles inner-city census tracts in old housing and found levels of 1.21 μmol per liter or higher (≥25 μg per dl) in 1.3% and levels of 0.72 μmol per liter or higher (≥15 μg per dl) in 19% to 20% of children tested.[1] A blood level of 1.21 μmol per liter or higher was then considered the "action level" for intervention, and a level of 0.72 μmol per liter or higher was chosen for testing because of a perceived probability that the level considered cause for concern would be decreased to within this range by the Centers for Disease Control (CDC). In October 1991, the CDC lowered the levels considered abnormal to 0.48 μmol per liter or higher (≥10 μg per dl),[2] thus increasing by 10-fold to 15-fold the number of children considered lead poisoned. The CDHS recently reported that according to 1987 and 1988 surveys, 67% of children tested in Oakland had lead levels exceeding this new 0.48 μmol per liter or higher action level.[3] Not stated was that the finger-stick, capillary method used in this study, described as "extremely inaccurate even when proper precautions were taken to avoid contamination," resulted in a false-positive rate of more than 50%.[1(p19)]

Subsequent to the 1989 CDHS report, evidence showed that both prevalence and risk of low blood lead levels in children have been greatly exaggerated. Because of a lawsuit brought by Matthews against Coye and settled out of court, the CDHS agreed to mandate blood lead screening, through public programs, for children in low socioeconomic groups; such children would be expected to have higher lead levels than the general population. To date, data on this group indicate blood lead levels are much lower than reported in the earlier Oakland study. Of 1,200 children tested by the San Francisco Health Department, 8.5% had blood lead levels of 0.48 μmol per liter or higher,[4] and of more than 1,000 children tested at Children's Hospital, Oakland, 14.6% had levels of 0.48 μmol per liter or higher (Patricia Chase, MD, unpublished data, 1992). Most, though not all, of the children tested at Children's Hospital were in public programs; some were higher-income children tested at their parents' request. Of 136 children in a private pediatric practice in East Oakland—mainly African-American children receiving Medi-Cal benefits—7.4% had levels of 0.48 μmol per liter or higher (Raymond Davis, MD, unpublished data, 1992). Recent childhood lead testing, using more accurate test methods and venous blood, indicated that the prevalence of blood lead levels of 0.48 μmol per liter or higher in Oakland is five to nine times lower than that reported by the CDHS, even though the groups tested were of low socioeconomic status. The 1989 CDHS report apparently exaggerated the prevalence of elevated blood lead levels in Oakland by selecting a very high risk group that was not representative of the area's general population (or even of children receiving public assistance) and by using seriously flawed testing methods.

Similarly, in the state of Washington, Konig and Robertson found that of 271 high-risk toddlers, only 6.3% had blood lead levels of 0.48 μmol per liter or higher, indicating that the data presented by the Environmental Defense Fund purporting a 40% prevalence at these levels were "severely flawed and grossly exaggerated."[5(p13)]

Similar charges of impropriety and poor methodology have been leveled against the leading United States protagonist of low lead levels damage.[6,7] In view of other more urgent health needs of our children, legislators and health officials in California and nationwide should be wary of allocating major funding to mass lead-screening programs until issues of misleading information, questionable statistical manipulation, and flawed data have been resolved.

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