others at risk for these disorders, and ignoring the NIH Consensus Statement with regard to this issue.[3] COL Pettett has accurately described the newborn screening "policy" of the US military and it is clear that COL Tiwary considers this inadequate, asserting, "State regulations for neonatal screening for metabolic diseases do not optimally serve the needs of the dependents of the US Armed Forces."[4]

As the uniformed services develop a comprehensive screening system to meet the needs of its dependents, it will be important to consider recommendations for the use of regionalized laboratories that have sufficient experience and sample throughput to assure adequate quality of their results.[5-7] The use of a US regionalized laboratory by European military facilities, beginning 2 years ago, is to be commended. It is not clear that other respondents to the survey cited by COL Pettett meet the appropriate criteria of experience and sample throughout.[1,6]

In my own clinical experience I have cared for three US military dependents with extremely late-treated phenylketonuria (PKU), all with developmental delay and behavioral problems attributable to inadequate screening and/or follow-up, and discussions with colleagues indicate that this experience is not unique. The first child was a 6-year-old boy with the diagnosis of autism and severe delay, whose sister was diagnosed with PKU after a positive newborn screening test. When taking the family history, I became concerned and these concerns were confirmed the next day when his serum phenylalanine was determined to be 35.4 mg/dL. He had been born in a Panamanian hospital because the military facility was full and Panama had no screening program. When he returned to the military facility for well child care, the only screening performed was a urine ferric chloride test, a test abandoned in the US in the 1960s because of its high false-negative rate and the development of the Guthrie bacterial inhibition assay. The second child was cared for by the same Medical Corps pediatric neurologist as the first boy, and this physician recognized their clinical similarities. This boy had been born in a military facility in Germany and his PKU screening test was performed by a military hospital laboratory. The third child was born in Korea and had a positive PKU screening test. When seen by the Medical Corps physician the parents were told that their baby's result must be incorrect because the mother was Korean and this physician stated that PKU did not occur among Koreans. (There is no data regarding the incidence of PKU in Korea; the incidence in China is similar to the US, and although the incidence in Japan is much lower, it does occur there). Her father recognized the similarity of her severe developmental delay and autistic symptoms to PKU when he was watching a television program describing PKU. These brief case histories show the need for programs developed for military dependents rather than reliance on local custom, the value of regionalized screening laboratories, and the importance of guidelines for follow-up when personnel encounter a positive screening test.

The Committee on Genetics has been working with the Uniformed Services Chapters of the American Academy of Pediatrics to develop forms for recording and prominent display of newborn screening results on the charts of dependents. This form will alert military physicians when results are outstanding to reduce the risk of missing a patient through inadequate follow-up. This simple and effective approach will be a model for the civilian community.

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Would Breast-Feeding Decrease Risks of Lead Intoxication?

To the Editor.—

As Shannon and Graef[1] point out, lead intoxication may be an important public health problem in young infants. And it is indeed likely that some babies receive too much lead from formula feeding. But this may be due to more than the fact that the lead content of the water is too high. Lead concentration of the formula itself, before dilution and even when packed in lead-free cans, may be several times that of human milk.[2] This has, as the authors point out, serious implications for infants fed on infant formula. Yet the authors never really seem to understand that the problem is one of formula feeding. Indeed, the words "breast milk" or "breastfeeding" are not used once in the whole article. By the way, how many of the 50 reported patients were breast-fed at all?

It is distressing that the authors suggest routine lead screening in children at 6 months of age, but ignore a more useful proposal. Promotion of breast-feeding, of more prolonged, and of exclusive or near exclusive breast-feeding up to 6 months of age would prevent excessive ingestion of lead by infants (as well as help prevent the iron deficiency mentioned as increasing the risk of plumbism) at a cost likely to be far less than the cost of routine testing. This, of course, requires hospitals and health professionals to be more aware of how to help mothers get started breast-feeding properly and how to help them continue if problems arise. Unfortunately, as is implied indirectly by the article, support of breast-feeding is rarely considered important.

It is a telling comment that 26% of the parents were "welfare-dependent." These parents would have the most to gain by their infants being breast-fed, not only because of cost, but also because of the prevention of illnesses, in addition to lead intoxication, which occur most commonly in the poor. If only a small percentage of the money used to buy formula for the Women, Infants, and Children program participants were used to promote breast-feeding, the benefits would be far reaching.

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In Reply.—

We thank Dr Newman for his comments and agree that, for many reasons, more can and should be done to encourage breast-feeding. Unfortunately, it is unclear that this practice protects infants from lead in any way and, inevitably, there will be some women who choose formula. While time did not permit us to re-review these cases, we estimate that, based on current data in our area, 60% to 70% of the infants in our study were breast-fed. Both the work of Rabinowitz et al[1] and a recent, as yet unpublished study (Hu H. Personal communication) conducted in the Boston area revealed unacceptably high concentrations of lead in breast milk samples obtained from some lactating women who delivered their infants at the Brigham and Women's Hospital. Indeed, lacta-