et al,[1] I offer a polyp, arising either from the cervix or vagina, as a more likely diagnosis. Figure 1 of the article fails to show any structure resembling a cervix. Ultrasonographic demonstration of a normal uterus and cervix, presumably in their normal location, is not consistent with the diagnosis of prolapse. If the anterior wall of the vagina were everted, as suggested in Figure 1, urinary retention would be most likely, or at least reduction of the urinary stream. A truly prolapsed vagina will not remain in position within the pelvis with increases in intraabdominal pressure. Defecation forces the vagina to descend each time. After 6 months, the polyp originally enlarged by maternal estrogen, may have diminished sufficiently not to have required repeated replacement. If vaginoscopy had been performed in the initial evaluation, it may have shown a cervix and anterior vaginal wall distinct from the mass, which would have allowed it to be amputated and not simply pushed back into the vagina. Vaginoscopy at the time of the last visit may still have shown a small polyp.

A true descent of the vagina is promoted by descent of either bladder, uterus, cul-de-sac, or rectum. Spontaneous regression of such a condition is unlikely. Fleshy prolapsed masses, as described, should be defined more explicitly, especially in relation to the urethra, vagina, and cervix because they may represent more ominous diagnoses, such as sarcoma botryoides.

As the authors point out, neonatal prolapse is associated most often with some form of spinal cord anomaly affecting the development of the levator muscle, the primary support of the pelvic organs.

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REFERENCES

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In Reply.—

We appreciate Dr Porges's suggestion of a possible diagnosis of polyp for the case published in September. In considering a differential diagnosis of interlabial mass during neonatal period, the partial list includes polyps, urethral prolapse, paraurethral cyst, and rhabdomyosarcoma (Botryoid sarcoma). However, the clinical findings in our case were relatively clear, which unfortunately was not revealed clearly in the published photograph. The photograph showed the circumferential prolapse of vaginal wall through the introitus and was not the cervix. When the prolapsed vagina was restored and kept in position with support (Fig 1), the gross anatomical structure of genital area was quite normal. Except for edematous or engorged vaginal wall secondary to maternal estrogens, everything was in place. The urethral opening was in the correct location and the urinary stream was normal.

The whole vaginal wall, engorged due to maternal estrogens, protruded through the introitus. As genital edema subsided and repeated reduction of the mass was performed, with time we were successful in maintaining the vagina in place. Pelvic ultrasonography, at 6 months, revealed the presence of normal uterus and cervix following reduction. However, in long-term follow-up, we may have to consider additional diagnostic evaluations as suggested by Dr Porges.

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Lead Screening

To the Editor.—

Dr Edgar J. Schoen does not like lead screening.[1] In a letter to *Pediatrics*, "Lead Toxicity in the 21st Century: Will We Still Be Treating It?" he refers to a study my colleagues at the California Department of Health Services and I conducted in Oakland, California as "a vivid example of how poor methodology and biased selection of subjects can lead to greatly exaggerated prevalence rates," accusing me of having a "serious omission" in a submission to *Morbidity and Mortality Weekly Report*. He goes on to contrast our findings with prevalence rates found in a number of unpublished clinical case series by practitioners in nearby communities and with results of a survey conducted in the state of Washington.

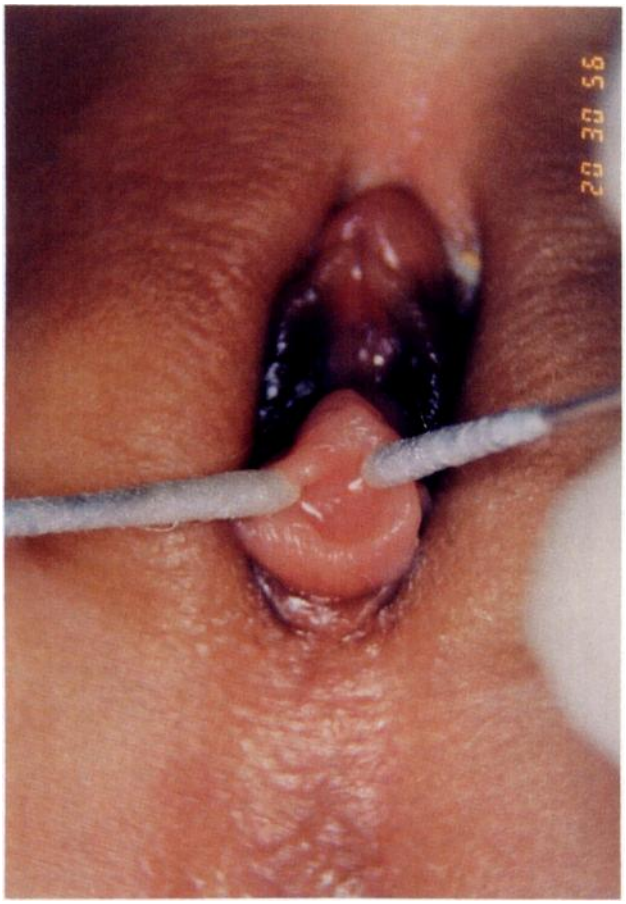

Fig 1. Normal anatomical structure after the reduction of the mass at birth.

Our study was a population-based sample of 544 children ages 1 to 6 in five census tracts in Oakland, California.[3] One objective of the study was to evaluate the sensitivity and specificity of the capillary fingerstick blood collection method compared with venipuncture for measuring blood lead. We did find that 10% of tests initially more than 25 μg/dL were less than 10 μg/dL on repeat venipuncture. Of those initially more than 15 μg/dL, 75% were lower on repeat, with 50% 10 to 15 μg/dL and 25% less than 10 μg/dL. Although we extensively discussed this issue in our report to the legislature, the data were not included in the *MMWR* report.[3] This was not a "serious omission" but one of many results from our study that didn't fit within the content of a brief report. The rate cited by Dr Schoen for the *MMWR* report (67% with blood lead >10) does not, as he implied, reflect those "false positives" above 15 μg/dL. Further, we never have tried to apply these rates beyond the boundaries of the study neighborhoods. The other studies that Dr. Schoen cites are actually two clinical case series in a hospital-based and private practice in the Oakland area. (The reference he cites for the rates in San Francisco and Oakland being 5 to 10 times lower was actually a study conducted in Seattle, not in California.) Dr Schoen does not mention a survey conducted by San Francisco County of children ages 9 months through 5 years in census tracts with high proportions of housing built before 1940. Of 1199 children screened, 99 (8%) had blood lead ≥10 μg/dL and 20 (0.7%) had blood lead levels ≥25 μg/dL.[4]

Case series studies are valuable in that they give estimates of the yield that can be expected from screening in various clinical settings. But it is difficult to compare data from case series with information from door-to-door surveys. In our study, about one-