

tion policy. Most importantly, it is imperative that the decision-making processes used to formulate such health policies proceed in an environment that stimulates and supports genuine discussion and debate, as implied by the AAP statement.

GEORGE A. GELLERT, MD, MPH, MPA  
Arizona Department of Health Services  
Phoenix, AZ 85105

GERALD A. WAGNER, MD, MPH  
ROBERTA M. MAXWELL, PhD  
DOUGLAS MOORE, PhD  
LEN FOSTER, MPA  
Orange County Health Care Agency  
Santa Ana, CA 92706

#### REFERENCES

1. American Academy of Pediatrics, Committee on Environmental Health. Lead poisoning: from screening to primary prevention. *Pediatrics*. 1993; 92:176-183
2. Schoen EJ. Exaggerated threat of childhood lead poisoning in California: epidemic by edict. *West J Med*. 1992;157:470
3. Gellert GA, Wagner GA, Maxwell RM, Moore D, Foster L. Lead poisoning among low-income children in Orange County, California: a need for regionally differentiated policy. *JAMA*. 1993;270:69-71

#### In Reply.—

Drs Gellert and Wagner have made some excellent points regarding the need to devise specific, local, lead poisoning prevention programs. Although the Letters to the Editor sections of journals are not the proper forum in which to devise such programs, several general comments should be made.

The Committee on Environmental Health carefully drafted its statement on childhood lead poisoning prevention to allow and encourage reasoned and reasonable discussion of screening strategies. The term "universal screening" is intentionally not used in the statement. The Committee has supported and continues to support efforts devising methods that may allow targeted screening. However, the Committee believes strongly that no strategy yet devised is an adequate surrogate for systematic screening of children. Prior anecdotal history for a community is not sufficient to determine that a lead poisoning problem does not exist. No demographic profile has yet been successful in defining populations safe from lead hazard. Until methods are devised to declare environments safe from lead hazard in a reliable fashion, there remains no safe alternative to broad-based routine screening of children.

Drs Gellert and Wagner have used the term "cost-benefit," but have focused on the cost. It is important to remember that the benefits of lead screening can be enormous. Early detection of lead exposure can prevent expensive medical care and hospitalization. It can decrease the need for special education. It can enhance the productivity of children who may have their intellectual potential damaged by lead toxicity. Furthermore, improvements to an exposed child's environment benefit not only that individual child but other children exposed to that environment both now and in the future. In a sense, the improvement in a child's environment is analogous to the "herd immunity" concept in immunization programs, because improvement in a single child's environment may benefit many children. We cannot wish lead hazards away, and they do not decrease with time. Only by removing them can the environment be made safe and primary prevention be accomplished. The Committee recognized that screening was only an interim strategy on the way to primary prevention when it drafted the title to the statement.

As we discuss cost-benefit analyses in an era when health care rationing appears inevitable, it seems to me important to remember that even the most expensive of preventive health care programs are far more cost-effective than most treatment programs. The question of allocation of health care expenditures under conditions of rationing should be framed first as whether it is better to emphasize prevention or treatment. The question of which prevention programs should receive support is clearly secondary to this primary question. Although it may seem that the cost of lead screening in lower risk populations is high and less effective than immunization, for instance, both of these provide greater benefit

for the cost than many expensive treatment programs. The cost per positive screen of \$310 quoted by Drs Gellert and Wagner seems insignificant compared with the several hundred thousand dollar expenditure necessary to benefit a single person by a heart or liver transplant. Some courses of treatment for a single case of otitis media can include \$50 or more in office visit fees and more than \$100 in medication cost. It has been argued rather persuasively that such expensive treatment regimens for otitis media are of little benefit to most patients.<sup>1</sup> Although I would not suggest that we abandon treatment of otitis media or stop efforts to improve organ transplantation, I strongly believe that preventive health efforts deserve a higher priority than they often have been accorded in the past.

It is my personal belief that pediatricians should work together to support effective preventive health programs of all sorts for children. We should promote the view that the wisest and most cost-effective use of limited health care dollars is in prevention. Only after full acceptance of this view will we be in a position to properly allocate expenditures among the various preventive programs available to us.

J. ROUTH REIGART, MD  
Dept of Pediatrics  
Medical University of South Carolina  
Committee on Environmental Health  
American Academy of Pediatrics

#### REFERENCE

1. Marchant CD, Carlin SA, Johnson CE, Shurin PA. Measuring the comparative efficacy of antibacterial agents for acute otitis media: the "Pollyanna phenomenon." *J Pediatr*. 1992;120:72-77

### Practice Guidelines for Management of Infants and Children With Fever Without Source (FWS)

#### To the Editor.—

While recognizing that the "Guidelines for Management of Fever Without Source"<sup>1</sup> are the result of a remarkable retrieval of information and a sophisticated statistical analysis leading to an admirable and helpful aid in decision making, I cannot help but observe that >90% of such decisions are made by practicing physicians outside the medical center without a supervising academician at hand. Because these are clinical guidelines, is it possible that nonacademic clinicians could have contributed to making the guidelines even more helpful?

DAVID TOLL, MD  
95 Main St  
St. Johnsbury, VT 05819

#### REFERENCE

1. Baraff LJ, Bass JW, Fleisher GR, et al. Practice guideline for the management of infants and children 0 to 36 months of age with fever without source. *Pediatrics*. 1993;92:1-12

#### To the Editor.—

As practicing pediatricians, we read with great interest the recent article by Baraff et al<sup>1</sup> regarding the management of febrile illnesses in children. The authors took great care to recommend an approach to this common problem which might be practically followed in both practitioners' offices and hospital emergency departments. Previous studies have documented the well-recognized disparity which exists between pediatric offices and hospital emergency departments regarding the laboratory evaluation performed in situations in which young children have fever without an apparent source. Unfortunately, several current pressures on private pediatric practitioners make it unlikely that the proposed algorithm for managing febrile children 3 to 36 months of age will be able to be applied in many offices in the near future.

In short, the major decision point in Baraff's algorithm is the presence or absence of leukocytosis, defined as a white blood count >15 000/mm<sup>3</sup>. Children with leukocytosis should then have