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## **The Folic Acid Debate Continues: In Reply**

Robert L. Brent and Godfrey P. Oakley, Jr

*Pediatrics* 2006;117;1460-

DOI: 10.1542/peds.2006-0012

**This information is current as of April 4, 2006**

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*In Reply.*—

We appreciate the historical perspective that Maberly provides the readers of *Pediatrics* concerning the obstacles that have confronted scientists when new ideas or discoveries have been proposed to the scientific and lay communities.<sup>1,2</sup> Maberly reflects on the lengthy battle that lasted more than a century before iodination of salt was established as an acceptable public health practice; even after acceptance occurred, there were a few doomsday predictors of catastrophe or poisonings.

We remember from our medical history the trauma and ridicule to which Ignatz Philipp Semmelweis, an Austrian obstetrician, was subjected when he suggested that child bed fever (puerperal fever) was a contagious disease that could be markedly reduced by having the physicians wash their hands before delivering their pregnant patients. He met bitter opposition from the medical community that at times amounted to persecution, and he eventually became insane. The attempt to introduce chlorination and fluoridation of water supplies met with opposition from the lay and scientific community because of concern about the hypothetical risk of cancer and other hypothetical adverse effects. Although both chlorination and fluoridation have markedly improved the health of numerous populations, there are still some lay groups and scientists who have suggested that hypothetical health risks outweigh their benefits.

No child should develop folic acid–preventable spina bifida anywhere in the world. It is tragic when prolonged scientific and policy debate about hypothetical risks prevents public health agencies from implementing public health programs that will be of significant benefit to men, women, and children. We have advocated, in 3 commentaries since 2000,<sup>3–5</sup> that the Food and Drug Administration (FDA) should maximize the prevention of folic acid–preventable neural tube defects by increasing the concentration of folic acid in “enriched” cereal grains. We believe that scientists and policy makers should sit down soon and objectively discuss our recommendation without being unduly influenced by those who raise hypothetical risks. When this discussion is held, we think that the FDA will increase the concentration of folic acid that is required in enriched cereal grain products. George Santayana wrote: “Those who cannot remember the past are condemned to repeat it.”<sup>6</sup> We hope that we do not repeat the iodine history with folic acid and thereby continue for many years to have children born with serious birth defects that could have been prevented by appropriate public health actions.

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doi:10.1542/peds.2006-0012

## Is Appendicitis the Only Cause of an Acute Abdominal Pain in Childhood?

*To the Editor.*—

Assessment and management of acute abdominal pain in the pediatric emergency department is recognized to be suboptimal much of the time. Green et al<sup>1</sup> drew attention to this and endeavored to dispel an old surgical legend that analgesia may hinder diagnosis in the child with acute abdominal pain.

Given the large throughput of their department (39 000 per annum), we were surprised that the number of patients eligible for the Green et al study was only 162. We see ~20 000 patients per year, and at least 1 patient per day will present with acute abdominal pain that merits a surgical consultation, an incidence of almost 2 in 100 attendances. The case histories cited led us to further question enrollment of patients into this study; one criteria was <48 hours of pain, yet 2 of the 4 patients discussed had >48 hours of pain.

The patient outcomes in the study were of interest. The only surgical diagnosis among the patients was appendicitis, and there was a low incidence of gynecologic and nonsurgical causes, contrasting with our own experiences. Most of the study population without appendicitis had self-resolving pain, yet no child in the study had mesenteric adenitis, a condition that we see commonly. We wonder whether this reflects a trans-Atlantic difference in practice and diagnostic definitions.

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