Letters to the Editor

Comments on the Contents of PEDIATRICS or any topic of general interest are invited. Queries and answers may be exchanged between correspondents. Letters should be in double-spaced typing on standard bond paper. Those accepted for publication will not be subject to editorial alteration except as to proper form. The Editor reserves the right to publish replies to letters and to solicit responses from authors and others.

This column has been established to provide a forum of all members of the profession for exchange of information and views. Statements and opinions expressed in letters are those of the authors and do not represent the official position of the American Academy of Pediatrics, Inc., or its Committees.

Prognosis of Childhood Leukemia

To THE EDITOR:

In his recent Commentary (PEDIATRICS, 45:191, 1970) on prognosis of childhood leukemia, the prime evidence cited by Dr. Holland to indicate significant improvement in survival due to vigorous antileukemic chemotherapy, is the performance of children in “Regimen D of AGLB, protocol 6601.” He asserts “seventy-five percent of these children are alive at 24 months.” The survival data plotted on his Figure 1 also indicate no deaths in the first year of therapy. These apparently remarkable therapeutic results become less impressive when the legend of Figure 1 is examined. It is then noted that in order to be included in Regimen D, a child must (1) have had remission successfully induced and then (2) have remained in remission on maintenance therapy for almost a year. Thus, Figure 1 is misleading, for it compares this group which was retrospectively selected on the basis of chemotherapeutic responsiveness to other series which include early relapses and deaths.

It may be that vigorous chemotherapeutic programs advocated by Dr. Holland and others will markedly prolong the lives of leukemic children and increase the percent of long term survivors. However, the preliminary data cited by him do not at present prove this hypothesis.

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The Pediatrician and the Marijuana Question

To THE EDITOR:

I would like to report my reaction to the views of Drs. Nader and Haggerty1 on the role of the pediatrician in the marijuana question. Their number two view, “The effects are dependent upon many factors, including the psychological makeup of the user,” seems to me to be the most urgent consideration at this stage of our knowledge.

It is unlikely that many of us are aware of our own psychological makeup and thus are unable to predict the outcome of a trial of the use of marijuana. Perhaps most of us would be able to escape the deleterious effects of such a trial as is the case in the use of alcohol. But the use of marijuana is fraught with many uncertainties; and, therefore, is a threat to anyone who would experiment with it. The experimenter may be in that percentage of us whose psychological makeup would not survive the trial, and unfortunately this would not be known until the damage has occurred.

We generally try to protect people from hazards, particularly those to which they are most vulnerable. We certainly have laws designed to protect youth from the misuse of alcohol on the assumption that they are not yet psychologically mature enough to handle it. This does not mean that the laws are necessarily good or that some other form of protection would not be better; the point is that some form of protection is necessary, and I believe that this is the prime consideration at the moment.

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Reference


To the Editor:

It is with deep satisfaction that I note the article1 on marijuana in the contributors section in the January issue of PEDIATRICS.

As an Academy member and now as a full
Prognosis of Childhood Leukemia
Howard A. Pearson

Pediatrics 1970;45;1037

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