in the United States."[2] Thus, we feel our data provide a far better estimate of the age distribution of the onset of puberty in US girls than the Marshall and Tanner study of 192 institutionalized white British girls published in 1969 upon which the 8-year cutoff has been based. We also pointed out that the girls could have been brought in selectively because of a problem with puberty, one of the mechanisms for selection bias discussed by Drs Rosenfield et al. We further stated that if such a bias had occurred we should have expected to see the same bias operating among parents of the older girls with no development, leading to a decrease in the prevalence of secondary sexual characteristics in that age group, a finding which did not occur.[2] For such a "hidden agenda" to affect the findings, the majority of parents would have had to be reluctant to bring up a concern about puberty even though that was the reason for the visit. It seems unlikely that so many would be reticent to discuss their reason for bringing a child to their pediatrician.

We noted that the age of menses had not dropped for white girls over the past 45 years and had dropped by several months for African-American girls since MacMahon's analysis of HANES data from the 1960s.[3] Our colleagues correctly noted that the implications of our study are that the tempo of puberty is slower. The purpose of our study was not to offer explanations for any of the findings, but simply to note the proportions at a given age with secondary sexual characteristics and menses from a large population of girls. Earlier puberty has been noted to be associated with a longer duration until menses.[4] It is interesting to note that the lengthening tempo has also been noted among Hong Kong girls. With 10% of their study population now with stage 2 breast development *before* the age of 8, the mean duration from breast budding to menses for Hong Kong girls is 6 months longer than it was in the early 1960s.[5]

We agree that puberty at an early age may not be "normal" even though a large proportion of girls are experiencing it because factors that may be contributing are not yet understood. We do not dispute that some girls with early signs of puberty may be at risk for subsequent reproductive dysfunction. However, we question the recommendation that all girls with the sole factor of breast development or pubic hair growth before 8 and 9 years of age, respectively, have a diagnostic evaluation. If this recommendation (which reflects standard practice before the recent revised guidelines) was followed, about 8% of all white girls in this country and 34% of all African-American girls would need such an evaluation. We believe the new recommendations for the evaluation of early puberty[1] are sound. They were approved by the leadership of the Lawson Wilkins Pediatric Endocrine Society in large part because 7- to 8-year-old white and 6- to 8-year-old African-American girls are commonly referred to endocrinologists for pubertal changes and are rarely found to have a pathologic cause.

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ERRATUM

Due to an oversight, a source of funding was inadvertently omitted from a recent article (Helton E, et al. Metabolic aspects of myocardial disease and a role for L-carnitine in the treatment of childhood cardiomyopathy. *Pediatrics*. 2000;105: 1260–1270). The Acknowledgments section for this article should have read as follows:

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We apologize for any confusion this omission might have caused.

Erratum

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