

vey, 2% for bitewing radiography, and 10% for panoramic radiography.³

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Lead Exposure and Cognitive Outcomes of Children With Prenatal Cocaine Exposure

To the Editor: We read with interest the article by Dr Singer et al¹ concerning the cognitive outcomes of preschool children with prenatal exposure to cocaine. The authors make a concerted effort to control for multiple confounding variables, including sex, intelligence of caregivers, and degree of cocaine exposure. They also stress the importance of the environment in which the children are placed as a determinant of their cognitive outcome. However, they do not address lead levels, an important environmental variable known to be strongly associated with both socioeconomic status and development of cognitive ability.²⁻³ We believe that the absence of this information may weaken their conclusions.

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In Reply: Drs Greller and Hoffman have made a relevant point about lead exposure as a possible confounding variable affecting outcome in our longitudinal study of children exposed to cocaine. It is well known that lead is an important variable associated with the poverty status of our sample and the devel-

opment of cognitive ability.¹ Although we did not collect data on lead exposure in our study, Nelson et al conducted a separate study² on our sample in which she assessed blood lead levels at 2 and 4 years. Although the entire sample was not included, there were totals of 143 children assessed at 2 years and 274 children at 4 years. At both time points, the prevalence of high blood lead level (≥ 10 mg/dL) was not different between the cocaine-exposed and nonexposed groups, nor were mean lead levels for the samples different. Therefore, lead exposure is unlikely to be a confounding variable for this cohort. Additionally, while lead levels independently predicted poorer performance and full scale IQs at 4 years and a lower Bayley Mental Development Index at 2 years, cocaine exposure was also an independent predictor of performance IQ in this subsample at 4 years.

The additive risk imposed from exposure to environmental toxins and nutritional deficiencies needs to be considered in outcome studies of high-risk children of low socioeconomic status and deserves further research as well as appropriate screening and interventional strategies for these populations.

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Nicotine Dependence and WHO Mental Health Surveys

To the Editor: The recent World Health Organization (WHO)-sponsored survey of serious mental disorders reported 12-month prevalence rates of substance use disorders ranging from 0.1% to 6.4% across locales.¹ Although not explicitly stated, these rates appear to exclude nicotine dependence. For example, the US 12-month prevalence rate of nicotine dependence alone ranges from 7.0% to 9.0%,^{2,3} yet the US 12-month prevalence rate of serious substance abuse/dependence in the WHO survey is 3.8%. Furthermore, since the current 12-month prevalence rate of tobacco use in several of the non-US countries surveyed by the WHO is 1.5 times the rates reported in the United States,⁴ 12-month prevalence rates of nicotine dependence in non-US countries are likely to be 10.0% or more.

Since most tobacco users are not able to stop despite repeated attempts, and half of tobacco users will die due to nicotine dependence-related disorders,⁴ it can be argued that nicotine dependence is one of the most serious mental disorders.