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Identifying Children With Autism Early?

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The American Academy of Pediatrics (AAP) policy statement “Identifying Infants and Young Children With Developmental Disorders: An Algorithm for Developmental Surveillance and Screening” (published in the July issue of Pediatrics) highlights the importance of ongoing developmental surveillance of all children during preventive care visits.1 Early identification of and intervention for developmental problems improves developmental outcomes and allays parental anxiety.2,3 This is particularly critical in children with autism spectrum disorders (ASDs), who may demonstrate significant developmental gains with early intervention.4,5 Although the average age of diagnosis of ASDs has decreased,6 many children still do not receive a definitive diagnosis of autism until the age of 3½ to 4 years or later.7,8

The policy statement recommends surveillance for developmental problems at all well-child preventive care visits and routine screening with a general screening tool at the 9-, 18-, and 30-month visits, plus screening with an autism-specific tool at the age of 18 months. Although we commend the statement for recommending screening with an autism-specific tool at the age of 18 months, in our opinion, screening with an autism-specific screening tool should be repeated at the age of 24 months. Autism-specific screening at the age of 24 months is important for several reasons. Because it is a scheduled visit in the AAP periodicity schedule, it is likely to be paid by the third-party payers. Most of the parents of children with ASDs become concerned when the child is between 17 and 19 months of age but do not seek advice until they are 21 to 25 months old.5 Regression is reported in ≥25% of children with autism. Because the mean age at which parents report autistic regression is 20 months,10 such cases may be missed if autism-specific screening is not repeated at 24 months. Because the sensitivity of currently available autism-specific screening measures ranges from 0.85 to 0.92 at best, repeating autism-specific screening at the age of 24 months is likely to increase the chances of identifying cases that were missed at 18 months.11,12 In all of these scenarios, screening at 18 months may miss children with ASDs because the parents have either not become concerned or not noted the signs of regression.

Although routine surveillance is valuable in the early identification of developmental disorders, it may miss children with ASDs unless pediatricians specifically elicit concerns and make observations about social reciprocity of children at all well-child preventive visits and make sure that children are using acquired language skills purposefully and appropriately instead of in a rote, scripted, or otherwise atypical manner. Although we agree with the recommendation in the policy statement that screening with an autism-specific tool should be performed at any age at which surveillance reveals concerns about a possible ASD, we want to reiterate that screening with an autism-specific tool should be performed routinely at 18 and 24 months.

Abbreviations: AAP, American Academy of Pediatrics; ASD, autism spectrum disorder

Opinions expressed in these commentaries are those of the authors and not necessarily those of the American Academy of Pediatrics or its Committees.

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The recommendation for developmental screening with a general or autism-specific tool at a 30-month visit may not be an effective approach even if third-party payers recognize this as an important visit to reimburse and pediatricians alter their current practice and routinely schedule children to return for health supervision at this age. Delaying screening until the age of 30 months may also delay the early intervention process, because the upper limit of entry in the early intervention system is 36 months. By the time a child identified at the age of 30 months is assessed, he or she may be too old to be evaluated and served through the early intervention program. Waiting until 36 months for evaluation by the local special education system would further delay potentially important intervention. Although 1-time screening at 18 months might offer a false sense of security, repeating autism-specific screening a second time would detect children whose symptoms were not apparent at 18 months or who had not yet regressed.

In summary, although we, the members of the AAP Autism Expert Panel,* agree with the authors of the policy statement that general screening for developmental issues is an important function of well-child care and that general developmental surveillance is likely to alert the practitioner to symptoms of autism at all well-child visits, we are of the opinion that autism-specific screening should be routinely repeated at the age of 24 months or at any encounter when a parent raises a concern.

*The AAP Autism Expert Panel is a group that was formed through the AAP Medical Home Surveillance and Screening Program to develop resources and materials about ASDs. Members of the panel are: Susan Hyman, MD, Co-chair; Chris Plauche’ Johnson, MEd, MD, Co-chair; James Bryant, MD; Barbara Byers; Vidya Bhusan Gupta, MD; Ronald Kallen, MD; Susan E. Levy, MD; Scott M. Myers, MD; Alan I. Rosenblatt, MD; and Marshalyn Yeargin-Allsopp, MD.

**REFERENCES**


**GIVE A BREAK TO AMERICANS GIVING BIRTH**

“Last month, The Washington Post ran one of those nauseating stories about all the fabulous maternity benefits women in France get: months of paid leave, government subsidies, free or low-cost day care and so on. I realize that nations like France, Japan, Sweden and others have reasons for providing generous financial support for new moms—stagnant population growth being one. But after taking my own meager maternity leave, mostly unpaid, hearing about policies like that makes me furious. I’m ashamed to admit this, but it has taken 40 years and the birth of my own child—five weeks ago, as I write—to awaken me to the fact that the United States is the only industrialized country that doesn’t guarantee some sort of paid leave to new mothers. According to a 2004 study by Jody Heymann, an associate professor at the Harvard School of Public Health, more than 160 countries offer some sort of leave for new mothers, paid by the government. Those that don’t include Papua New Guinea, Swaziland, Lesotho—and the United States.”


Noted by JFL, MD
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ERRATA


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Several errors occurred in the article by Vohra et al, titled “Adverse Events Associated With Pediatric Spinal Manipulation: A Systematic Review” published in the January 2007 issue of Pediatrics Electronic Pages (doi:10.1542/peds.2006-1392). In Table 1, the entry in the “Shafrir and Kaufman” row, “Time to Adverse Event” column, should read: “Immediately after first SM.” Also, in the “Shafrir and Kaufman” row, “Type/Schedule of Spinal Manipulation” column, the phrase “at least 3 SMs over 2 d” should read: “2 SMs over 2 d.” In Table 2, an entry was omitted from the “Adverse Event” column of the “Nickerson et al.” section. The missing entry is as follows: “Delayed treatment for diabetes mellitus; NS; NS; NS.” The errors have been corrected online.

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