

# Letters to the Editor

## Well-Child Visits Provide Physicians Opportunity to Deliver Interconception Care to Mothers

**Original Article:** Well-Child Visits for Infants and Young Children

**Issue Date:** September 15, 2018

**See additional reader comments at:** <https://www.aafp.org/afp/2018/0915/p347.html>

**To the Editor:** The article by Dr. Turner on well-child visits for infants and young children is well written and comprehensive, highlighting the various aspects of anticipatory guidance that family physicians need to address for parents of young children.

An additional area of guidance that family physicians can provide is the assessment of maternal behavioral risk factors. The impact of maternal health on the health of children is well understood, so these interventions fit naturally into the context of well-child care because these risks affect the child's health and the health of future pregnancies.<sup>1</sup>

Based on this premise, the Family Medicine Education Consortium's Interventions to Minimize Preterm and Low Birthweight Infants through Continuous Quality Improvement Techniques Network ([www.fmec.net/implicit](http://www.fmec.net/implicit)) developed a proactive approach to interconception care. As a quality initiative project, the interconception care model uses this opportunity to specifically target four maternal behavioral risk factors—tobacco use, depression, family planning, and multivitamin use—by screening current actions, reinforcing desired behaviors, and offering interventions during well-child visits. After an initial pilot phase, the project is now incorporated as an essential part of routine well-child care for infants younger than two years.

At the time of this letter, nearly 14,000 mother-child dyads have been followed at our 19 participating network sites. Our demographic data show this model of interconception care especially reaches low-income minority women who are at the greatest risk of having preterm and low birth weight

infants. Data collected demonstrate that mothers accompanied their babies to 93.5% of visits, making well-child visits an opportune time to reach women.<sup>2</sup> The model can also be adaptable to a variety of practice settings; any site in which women and babies are seen together is an ideal situation for delivering interconception care, including family medicine, pediatrics, health departments, community health centers, and public health programs. We believe that this brief but powerful assessment has the potential to lead to healthier mothers and babies.

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## References

1. Kahn R, Wide P. The scope of unmet maternal health needs in pediatric settings. *Pediatrics*. 1999;103(3):576-581.
2. Srinivasan S, Schlar L, Rosener SE, et al. Delivering interconception care during well-child visits: an IMPLICIT Network study. *J Am Board Fam Med*. 2018;31(2):201-210.

**Editor's Note:** This letter was sent to the authors of "Well-Child Visits for Infants and Young Children," who declined to reply.

## Use of More Specific Terminology May Assist in Better Diagnosis of Abdominal Wall Injuries

**Original Article:** Abdominal Wall Pain: Clinical Evaluation, Differential Diagnosis, and Treatment

**Issue Date:** October 1, 2018

**See additional reader comments at:** <https://www.aafp.org/afp/2018/1001/p429.html>

**To the Editor:** We agree with Drs. Shian and Larson that a complete understanding of the underlying anatomy is essential to narrow the differential diagnosis of abdominal wall pain. To this end, we suggest that clinicians no longer use the term sports hernia. As stated in the article, the term is a misnomer, and its use may lead to confusion among patients and physicians. Furthermore, studies have found that 11 to 33 different diagnostic terms have been used in the medical literature to describe this condition.<sup>1,2</sup>

In response to the imprecise and widening vocabulary used to describe groin and lower abdominal pain in athletes, five categories for groin pain—defined by the affected anatomic

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region—were recommended at the 2015 Doha agreement meeting: adductor-related, iliopsoas-related, inguinal-related, pubic-related, and hip-related groin pain.<sup>2</sup> When a specific source of pain cannot be identified, the general term groin pain can be used. Removal of the terms sports and athlete was recommended because these injuries are not limited to athletes.

Appropriate use of the terms recommended by the Doha agreement may assist in better classification and diagnosis of abdominal wall injuries and in decreasing the heterogeneity among diagnostic terms. With better classification, we can avoid situations where patients hear the term sports hernia and believe they need surgery. This in turn could lead to more focused and specific treatment, and hopefully better understanding and outcomes for our patients.

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## References

1. Serner A, van Eijck CH, Beumer BR, Hölmlisch P, Weir A, de Vos RJ. Study quality on groin injury management remains low: a systematic review on treatment of groin pain in athletes. *Br J Sports Med*. 2015;49(12):813.
2. Weir A, Brukner P, Delahunt E, et al. Doha agreement meeting on terminology and definitions in groin pain in athletes. *Br J Sports Med*. 2015;49(12):768-774.

## Corrections

**Anatomy clarification.** The article “Renal Cell Carcinoma: Diagnosis and Management” (February 1, 2019, p. 179) incorrectly identified the right testicular venous system as draining to the right renal vein rather than the inferior vena cava in the third sentence of the “Clinical Presentation”

section (page 180). The sentence should have read: “Nonreducing or isolated right-sided varicocele and bilateral lower extremity edema can also be symptoms of advanced disease through occlusion of the right testicular venous system that drains directly to the inferior vena cava.” The online version of the article has been corrected.

**Incorrect amount listed in table.** The article “Gastroenteritis in Children” (February 1, 2019, p. 159) contained an error in the last column of row two of Table 4 (page 162). The table incorrectly identified the amount of oral rehydration solution (ORS) to give in the first four hours for children weighing 5 to 7.9 kg (11 lb to 17 lb, 7 oz) as 200 to 400 mL rather than 400 to 600 mL. Table 4 is reprinted below and the online version of the article has been corrected. ■

TABLE 4

### WHO Guidelines for Administering ORS in Children

Weight*	Age*	Approximate amount of ORS (mL) to give in the first four hours
Less than 5 kg (11 lb)	Younger than four months	200 to 400
5 to 7.9 kg (11 lb to 17 lb, 7 oz)	Four to 11 months	400 to 600
8 to 10.9 kg (17 lb, 10 oz to 24 lb)	12 to 23 months	600 to 800
11 to 15.9 kg (24 lb, 4 oz to 35 lb)	Two to four years	800 to 1,200
16 to 29.9 kg (35 lb, 4 oz to 65 lb, 15 oz)	Five to 14 years	1,200 to 2,200
30 kg (66 lb, 2 oz) or more	15 years or older	2,200 to 4,000

**Note:** If the patient wants more ORS than shown, give more. Encourage breastfeeding mothers to continue breastfeeding the child. For infants younger than six months who are not breastfed: if using the old WHO ORS solution (90 mEq per L of sodium), add an extra 100 to 200 mL of clean water; this is not necessary if using the new reduced osmolarity ORS (75 mEq per L of sodium).

ORS = oral rehydration solution; WHO = World Health Organization.

\*—Use the patient’s age only if the weight is not known. The approximate amount of ORS required (in mL) can also be calculated by multiplying the patient’s weight in kg by 75.

Adapted with permission from World Health Organization. *The treatment of diarrhoea: a manual for physicians and other senior health workers*. 2005. <http://apps.who.int/iris/bitstream/10665/43209/1/9241593180.pdf>. Accessed January 3, 2018.