to their inclusion in a broadly study-defined LD group. For example, 2 children who were subsequently diagnosed with an LD had Sturge-Weber syndrome, and another child had cerebral palsy. It thus seems reasonable to question whether the LDs in these children are really ‘‘in excess’’ of those usually associated with these medical conditions.

Furthermore, the authors report an incidence of LDs in the Olmsted County, Minnesota general population as 20.0% for children not receiving an anesthetic, and 20.4% and 35.1% in children receiving one or multiple anesthetics, respectively. This is significant because the inclusion criteria used for the diagnosis of an LD in the authors’ study resulted in an incidence more than double that reported in the 2007 Summary Health Statistics for U.S. Children: National Health Interview Survey, which reported an LD incidence of 8% in children aged 3–17 yr. In addition, the LD prevalence reported in the Diagnostic and Statistical Manual of Mental Disorders ranges from 2% to 10%, depending on the diagnostic criteria used. Finally, in examining the authors’ previous publications based on the same population cohort, the ‘‘low achievement criteria’’ diagnosed reading disability (11.8% vs. 5.3%) and math disability (15.8% vs. 5.9%) at more than double the rate of the criteria used by the Minnesota Department of Education, and significantly higher than the other diagnostic criteria used in the current study. Indeed, it would be interesting to view the results obtained when each diagnostic criterion used in the current study was displayed individually (similar to the authors’ previous studies of this same population).

The study of anesthetic effects on childhood neurodevelopment is both timely and clinically relevant, and the authors are to be commended for attempting the difficult task of translating animal research findings into humans. However, more rigorous clinical evaluations of the effects of anesthetics on the developing human brain, including controlling for potential confounders (e.g., medical diagnoses, type of surgery, prenatal history) using a multivariate model and propensity scoring are needed before drawing a link between anesthetic use in children and the subsequent development of LDs. As suggested by the title, the lay media is all too quick to jump on such an extremely controversial and sensitive topic, while at the same timepreying on parents’ worst fears.

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To the Editor:—We commend Dr. Wilder et al.4 for their work titled “Early Exposure to Anesthesia and Learning Disabilities in a Population-based Birth Cohort.” In their article, they report that patients younger than 4 yr, with two or more exposures to general anesthesia, had a greater proportion of learning disabilities (LDs) compared with children who had one or no exposure to general anesthesia. This represents a clinically important epidemiologic correlate to compliment the worrying animal observations demonstrating the detrimental effects of general anesthesia on the developing brain.

A primary assumption in cohort analyses is that the groups observed are the same before exposure. However, children requiring anesthesia for surgical treatment may be inherently different from those who do not; these differences may present unique factors that predispose to LDs independent of anesthesia per se. In particular, we are concerned that a subpopulation at risk for learning disabilities—children undergoing ear, nose, and throat surgery—is overrepresented. Typical ears, nose, and throat surgeries in this age group include adenotonsillectomy, bilateral myringotomy, and yttrium-erbium:glass laser ablation for obstructive sleep apnea. Moreover, the duration and depth of anesthesia may be more onerous for children undergoing tonsillar or myringotomy surgeries.

We are interested to know whether the authors could remove patients who underwent adenotonsillectomy and bilateral myringotomy to determine whether a relation between anesthesia and LDs persists.

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Surgical Diagnosis Is an Important Variable to Consider in Postanesthesia Exposure–associated Learning Disabilities

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A primary assumption in cohort analyses is that the groups observed are the same before exposure. However, children requiring anesthesia for surgical treatment may be inherently different from those who do not; these differences may present unique factors that predispose to LDs independent of anesthesia per se. In particular, we are concerned that a subpopulation at risk for learning disabilities—children undergoing ear, nose, and throat surgery—is overrepresented. Typical ears, nose, and throat surgeries in this age group include adenotonsillectomy and bilateral myringotomy with tympanostomy tube placement. The former is associated with obstructive sleep apnea, which can result in neurocognitive defects;5 the latter may be associated with otitis media with effusions, which can yield poor performance in expressive speech and math testing in younger children.3

These coexisting conditions may have skewed the diagnosis of LD in this population. This is relevant because children tested within a short period of time from their ears, nose, and throat surgery may not have had sufficient time to “catch up” with their peers in terms of testing, should the surgery have improved their condition. Furthermore, given the frequency of achievement tests administered to the cohort population, is it possible to find children who no longer met LD definitions at some point during follow-up testing? This would be of particular interest for those children undergoing ear, nose, and throat surgeries.

In addition, we are concerned that the third definition of LD included patients in the low-average IQ range versus average intelligence. Moreover, using a cutoff of 1.75 SDs below their predicted average intelli-

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