years, the available data permit only tentative estimates, not definitive conclusions. In any case there was no suggestion—let alone substantial evidence—that the number of afflicted survivors of neonatal intensive care was of an order of magnitude sufficient to account for a significant part of the one million plus increase in children with reported limitation of activities. On balance, then, the available evidence suggests that improvements in technology should have resulted in net reductions or at most a leveling in moderately and severely disabled children counted by the National Health Interview Survey.

One other indication that improved survival rates probably have not contributed to increased reporting of childhood disabilities comes from our AJPH article. There we reported that while the overall increase in prevalence of activity limitations has been slightly higher for preschool children compared to school-age children, three-fourths of the increase for preschool children occurred prior to 1969. Since 1969, the greatest increase in prevalence has occurred in school-age children. Had the decline in fetal mortality rates between 1968 and 1978 cited by Reich, et al., contributed to greater numbers of children with activity limitations, we would expect to have seen a more rapid increase in prevalence among preschool children compared to school-age children.

Future reports from our study will discuss trends for specific chronic conditions and perhaps help clarify further the role of increased neonatal survival.

REFERENCES


Paul W. Newacheck, MPP
Peter P. Budetti, MD, JD
Margaret A. McManus, MHS
Institute for Health Policy Studies, UCLA School of Medicine, 1326 Third Avenue, San Francisco, CA 94143

Social Support Networks: Some Added Dimensions

I would like to respond to the recent editorial on social support and the development of vulnerable children. The editorial is an excellent summary of most of our knowledge in the field, and it is certainly a very popular topic. There are three issues which must be added.

• First, recent work has shown that social support networks not only make a positive contribution but add to the experiences of stress, i.e. the network makes demands on us to respond to the crises of other people.*

• Second, the support network discussed mostly in the editorial is the "natural" support network and not a professionally supplied network. Although professionally supplied networks can substitute, their difficulty is that they tend to end and then things revert to the previous condition.

• Third, many of the mothers that we are most concerned about are over-dramatic, emotionally labile, unstable and impulsive women whose lack of social network may be in part a response to their temperamental traits. Many of these individuals have very little motivation for change, so that even if medication might help some of them achieve a better level of self-control they are not likely to take it regularly and any artificial attempt to create a social support network, whether of professionals or lay individuals, is likely to wear out sooner or later because these people are very hard to take. This probably genetically determined dimension is further complicated because mothers of this type are at greater risk to produce difficult infants with the same kind of temperament who then increase the level of stress in the situation.

REFERENCE


Hans R. Huessy, MD
Professor of Psychiatry, The University Associates in Psychiatry, 1 South Prospect, Burlington, VT 05401


Interpreting Trends in Vital Statistics

H owe's article on the effect of hysterectomy and oophorectomy prevalence rates on the risks for cancer of the reproductive system points out an important phenomenon regarding the interpretation of vital statistics—especially trends in vital statistics—for these diseases. We became aware of the problem while developing a computerized pre-screening instrument based on health risk appraisal techniques. In order to project individual risks for cervical, endometrial, and ovarian cancer accurately, we found it necessary to adjust the mortality rates to reflect presence of an organ at risk. After examining the various national data sources cited by Howe, we too found it necessary to conduct a sample survey in Champaign-Urbana, Illinois, in 1981–82. Despite differences in the two regions, our findings were very similar to hers. The hysterectomy and oophorectomy rates from our survey and the per cent increase of the adjusted rates incorporated in our risk assessment instrument in 1982 are as follows:

Prevalence of Hysterectomy and Oophorectomy by Ten-Year Age Groups and Effect on Reported Incidence and Mortality Rates, Champaign-Urbana, Illinois, 1982

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>N</th>
<th>Hysterectomy % Increase</th>
<th>Adjusted rates</th>
<th>Bilateral % Oophorectomy % Increase</th>
<th>Adjusted rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>30–39</td>
<td>85</td>
<td>2.4</td>
<td></td>
<td>4.7</td>
<td>5</td>
</tr>
<tr>
<td>40–49</td>
<td>95</td>
<td>13.7</td>
<td></td>
<td>17.9</td>
<td>22</td>
</tr>
<tr>
<td>50–59</td>
<td>65</td>
<td>23.1</td>
<td></td>
<td>30.2</td>
<td>14</td>
</tr>
<tr>
<td>60–69</td>
<td>57</td>
<td>22.8</td>
<td></td>
<td>30.2</td>
<td>19</td>
</tr>
<tr>
<td>70–75</td>
<td>25</td>
<td>36.0</td>
<td></td>
<td>56.0</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>327</td>
<td>15.9</td>
<td>19</td>
<td>12.5</td>
<td>14</td>
</tr>
</tbody>
</table>

*Research supported by American Cancer Society, Illinois Division

We join Howe and others in recommending that these data be routinely collected on a timely basis so that trends in disease incidence can be properly evaluated.

REFERENCES


Harriet H. Imrey, PhD
Director of Research, Regional Health Resource Center, 1408 W. University Ave., Urbana, IL 61801

Relation of Football Injuries to Exposure Time

I would like to congratulate Dr. Gerberich, et al., on researching a very important topic "Concussion Inci-