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OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

## TORCHES

Roger A. Brumback  
*Pediatrics* 1976;58;916

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The PDQ may be one instrument which can assist all in the health and educational field who interact with young children and families to fulfill an important responsibility to those children at risk for speech and language disorders.

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#### TORCHES

TO THE EDITOR:

In the July 1975 issue, Fuerst<sup>1</sup> suggested that the acronym for the common congenital infections be changed from TORCH to STORCH in order to include another important congenital infection, syphilis. I would like to recommend an acronym used by some pediatricians to designate the pentad of congenital infections: TORCHES (TOxoplasmosis Rubella Cytomegalovirus HERpes Syphilis). Substituting TORCHES as the acronym for the common congenital infections may be more readily accepted and recognized by pediatricians familiar with the older acronym.

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#### A Cannabis Registry?

TO THE EDITOR:

The report of the Committee on Drugs on the effects of marijuana on man<sup>1</sup> is commendable for its thorough survey of the current literature and its succinct presentation of a complex subject.

I would like to add some comments in regard to adverse psychological effects, an aspect of the marijuana problem that is of special interest to pediatricians.

The Committee discounts many reports of adverse effects on several grounds: uncontrolled observations, data from the Far East and Caribbean of doubtful clinical verity on men with nutritional and other disease problems, and the confusion of interpreting multiple drug effects.

While controlled studies are considered the desideratum of modern pharmacology, many drugs were established as clinically useful long before the era of double-blind studies—digitalis, opiates, salicylates, and mercurial diuretics to name a few. Similarly, other substances were identified to be deleterious without resort to controlled studies, for example, vinyl chloride, asbestos, radium, and tobacco. Indeed, the insistence upon controlled studies of cigarette usage added little to clinical awareness and greatly delayed the articulation of a definitive public health policy.

The problem in demanding controlled and double-blind studies of cannabis is that, owing to ethical research constraints as well as good common sense, the subjects about whom we need data, namely, children and adolescents and women, cannot be used as experimental subjects. All reported controlled studies are performed, the protocols specify, on normal, healthy, male volunteers. How does one extrapolate from these findings to the pediatric population?

To disqualify observations of adverse psychological effects on grounds of a multiple drug effect is to deny one of the significant insights of modern pharmacodynamics, namely, the additive and potentiating effects of drug combinations. If alcohol and marijuana are demonstrated to have additive effects in impairing motor and psychological effects, so be it. We should be searching for other such negative effects rather than denying what we observe.

Since we cannot employ children and youths as experimental subjects, we are obliged to rely upon clinical experience, the traditional method of Western medicine and one that has withstood the test of time. Many instances<sup>2-12</sup> of adverse effects of cannabis as used by American youths are on record and many more would be apparent if clinicians were alert to the symptoms and the possibility of drug intoxication and made a systematic inquiry. I have hypothesized that many instances of cannabis toxicity go unrecognized because young people experience these reactions in the protected environment of their homes or college dormitories. Only when the reaction is prolonged or complicated by recurrent "flashbacks" does the young person come to medical attention.

If psychological vulnerability or predisposition is the risk factor in adverse reactions, then the adolescent is uniquely vulnerable, owing to the special features of the adolescent personality: fluidity of self-identification, ambivalence in regard to parents, conflict between dependent and autonomous strivings, and the struggle toward heterosexual maturity.

In summary, there is need for more information on the child and adolescent population, utilizing whatever clinical experience is available. As a beginning, I suggest that the Academy establish a registry of all instances and suspected instances of adverse psychological reactions to cannabis. From such monitoring, a body of clinical data might emerge which would be a useful alternative to controlled, double-blind, prospective studies.

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