

ence in the overall mortality but a puzzling lower incidence in the somewhat subjective measure of “RDS [respiratory distress syndrome]-related mortality” in the lucinactant group, whereas the incidence of respiratory distress syndrome and all measurements of the degree of respiratory support required were not different. Both trials were underpowered for detecting “noninferiority” to the natural surfactants; the former was underpowered by premature closure of the trial, and the latter was underpowered by design.

My commentary was not intended to malign either of these very ambitious trials, both of which have added important information to the surfactant story. The purpose was to caution that this is not the end of the story. We should continue to search for the optimum synthetic protein(s) that will most effectively mimic the endogenous substance. The synthetic surfactant using sinapultide as the protein is clearly superior to its predecessors and represents a significant step in the right direction.

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Noise-Induced Hearing Loss in Young People

To the Editor.—

The excellent article by Chung et al¹ concluded that 61% of the young people who responded to their Web-based survey experienced tinnitus or hearing loss as a result of attending loud music concerts. Also, 43% of the respondents experienced these auditory symptoms after exposure to loud music in clubs. However, only 14% of the respondents ever wore ear plugs at a venue in which loud music was played. Fortunately, a majority of the respondents (66%) could be motivated to try hearing protection if they knew that limited exposure to very loud music can permanently damage hearing. Most respondents (59%) were also more likely to use ear plugs if a doctor or nurse recommended hearing protection.

The study highlights the following facts about noise-induced hearing loss (NIHL) and hearing-loss prevention: (1) young people are often exposed to hazardous levels of sound (in addition to loud music, such levels can be produced by, eg, power tools, gunfire, loud machinery, or engines); (2) exposure to excessively loud sounds can result in hearing loss and tinnitus; (3) people are often unaware of the consequences of excessive sound exposure; and (4) when people become aware of these consequences, they are more willing to take steps to protect themselves against NIHL and tinnitus.

Colleagues and I agree with numerous experts that, over the last 30 years, have recommended the implementation of hearing-loss-prevention education in schools.^{2,3} Unfortunately, basic hearing-conservation information (which could prevent many cases of NIHL) remains conspicuously absent from most school curricula. We identified the following reasons for this omission: (1) lack of public awareness about how excessive sound exposure damages hearing and the consequences of hearing loss; (2) lack of effective dissemination of existing hearing-conservation programs, curricula, and materials; and (3) lack of a mandate from local and state school boards and state or federal health agencies.

Healthy People 2010⁴ lists the following objectives for hearing: “Increase the use of appropriate ear protection devices, equipment, and practices; reduce noise-induced hearing loss in children and adolescents aged 17 years and under; reduce adult hearing loss in the noise-exposed public.” A public health campaign should be waged to accomplish these objectives. A good place to start would be for the Centers for Disease Control and Prevention to add NIHL to its list of “important health topics” within its Healthy Youth! program.⁵ This would facilitate implementation of hearing-loss-prevention education in our nation’s schools. Eventually, such programs would help to reduce the prevalence of NIHL, a potentially debilitating condition that is almost entirely preventable.⁶

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In Reply.—

We thank Dr Folmer for his insightful comments. A paradoxical issue with concerts (personal listening devices, clubs, and other musical venues) is that loud musical sound is marvelous and attractive, although the sound levels can be as loud as the noxious noise from a jackhammer, which would cause an individual to protect his or her ears from the sound source; the damage to the inner ear is the same. The public must be made aware that exposure to loud sound can cause permanent hearing loss. Like so many health issues, educating children (whether at school, at home, or via the media) before the problem occurs is a better solution than trying to convince adolescents and young adults to reverse a habit that is enjoyed. A public-awareness campaign and high-profile prioritization similar to that for bicycle helmets, seat belts, and sunscreen will be an important tool to help our pediatric patients and our fellow citizens.

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***Kingella kingae*: An Emerging Pathogen of Acute Osteoarticular Infections in Children**

To the Editor.—

We read with interest the *Pediatrics electronic pages* article by Kiang et al,¹ “Outbreaks of Osteomyelitis/Septic Arthritis Caused by *Kingella kingae* Among Child Care Center Attendees.” *K kingae* has emerged as an important pathogen of acute osteoarticular infections in children. It may be responsible for up to 50% of previously undiagnosed suppurative bone and joint infections in children <2 years of age.² The bacteriologic data of clinically suspected osteoarticular infections affecting 406 children hospitalized in the pediatric orthopedic surgical unit of the Necker-Enfants Malades Hospital (Paris, France) during a 3.5-year period (1999–2002) were reviewed retrospectively.³ The bacterial cultures from clinical specimens were positive in 74 cases (18%): 38 cases of septic arthritis and 36 cases of bone infections (osteitis, osteo-

myelitis, or osteoarthritis). The most commonly recovered pathogen was *Staphylococcus aureus* (44%) followed by *K kingae* (14%), *Streptococcus pyogenes* (10%), and *Streptococcus pneumoniae* (10%). *K kingae* was isolated most frequently among children <36 months of age.

In recent years, there have been an increasing number of reports on osteoarticular infections caused by *K kingae* in young children,^{1,3} which may be the result of improved isolation techniques and clinical suspicion (eg, infection among child care center attendees,¹ arthritis following stomatitis⁴). Recovery of this fastidious bacterium can be improved significantly by inoculation of synovial fluid and bone exudates into an aerobic blood-culture bottle with a continuous monitoring system and holding-culture plates for up to 7 days.⁵ Physicians who are caring for children with skeletal infections should be aware of this fastidious organism.

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In Reply.—

We greatly appreciate the comments from Drs Saphyakhajon and Greene, which reinforce the importance of recognizing *Kingella kingae* as a significant pathogenic cause of osteoarticular and other infections among young children. The growing body of knowledge surrounding *K kingae* over the past decade reflects, in part, our increasing awareness of the organism and ability to isolate it in the laboratory. As stated in our article, no causative organism is found in 40% to 70% of cases of pediatric osteoarticular infections,^{1–5} and up to 84% to 91% of cases of *K kingae* infection are missed if only the conventional culture technique is used without an accompanying blood-culture–bottle method.^{6–9} The retrospective study by Moulmille et al¹⁰ reported that *K kingae*