

28. Pajkrt D, Benschop KSM, Westerhuis B, Molenkamp R, Spanjerberg L, Wolthers KC. Clinical characteristics of human parechoviruses 4–6 infections in young children. *Pediatr Infect Dis J* 2009;28:1008–10.
29. Abedi GR, Watson JT, Nix WA, Oberste MS, Gerber SI. Enterovirus and parechovirus surveillance—United States, 2014–2016. *MMWR Morb Mortal Wkly Rep* 2018;67:515–8.
30. Braccio S, Kapetanstrataki M, Sharland M, Ladhani SN. Intensive care admissions for children with enterovirus and human parechovirus infections in the United Kingdom and the Republic of Ireland, 2010–2014. *Pediatr Infect Dis J* 2017;36:339–42.
31. Midgley CM, Jackson MA, Selvarangan R, Franklin P, Holzschuh EL, Lloyd J, et al. Severe parechovirus 3 infections in young infants—Kansas and Missouri, 2014. *J Pediatric Infect Dis Soc* 2018;7:104–12.
32. Britton PN, Dale RC, Nissen MD, Crawford N, Elliott E, Macartney K, et al. Parechovirus encephalitis and neurodevelopmental outcomes. *Pediatrics* 2016;137:e20152848.
33. Britton PN, Khandaker G, Khatami A, Teutsch S, Francis S, McMullan BJ, et al. High prevalence of developmental concern amongst infants at 12 months following hospitalised parechovirus infection. *J Paediatr Child Health* 2018;54:289–95.
34. Obermeier PE, Karsch K, Hoppe C, Seeber L, Schneider J, Mühlhans S, et al. Acute disseminated encephalomyelitis after human parechovirus infection. *Pediatr Infect Dis J* 2016;35:35–8.
35. Chang JT, Chen YS, Chen BC, Huang TS, Chang TH. Human parechovirus infection in children in Taiwan: a retrospective, single-hospital study. *Jpn J Infect Dis* 2018;71:291–7.
36. Debiaggi M, Canducci F, Ceresola ER, Clementi M. The role of infections and coinfections with newly identified and emerging respiratory viruses in children. *Viol J* 2012;9:247.
37. Rahimi P, Naser HM, Siadat SD, Sohrabi A, Mostafavi E, Motamedirad M, et al. Genotyping of human parechoviruses in Iranian young children with aseptic meningitis and sepsis-like illness. *J Neurovirol* 2013;19:595–600.

50 Years Ago in *THE JOURNAL OF PEDIATRICS*

Does One Size Fit All? High-Value Care For Learning and Developmental Concerns

Kenny TJ, Clemmens RL. Medical and Psychological Correlates in Children with Learning Disabilities. *J Pediatr* 1971;78:273–77.

This article discusses the utility of neurologic and psychological evaluations, as well as the benefit of electroencephalography (EEG) in the assessment of 100 children. Children included in the study were referred to the central evaluation clinic at the University of Maryland Hospital for behavioral, learning, or developmental concerns suggesting possible minimal brain dysfunction (MBD), one of the previous lenses through which children who might now be identified as having attention-deficit/hyperactivity disorder were viewed. Most were referred via the school system or a physician. In their discussion, the authors advocate for a more thoughtful approach to evaluating children with suspected MBD. The learning problems that subjects most likely had were usually identifiable by school systems. The authors found little value added by comprehensive neurologic examinations and EEG. Their article mirrors discussions that continue today around high-value care.

High-value care emphasizes “restraint, stepwise decision-making, plans that avoid excess, and the incorporation of patient and family perspectives.”¹ With this practice, a clinician must understand the benefits and costs of specific tests, procedures, or interventions, accurately identifying those with maximum benefit to her patient and minimal expenditure of resources. Like other pediatric specialties, developmental pediatrics has grappled with how to recommend the most cost-effective and vital tests and interventions for patients, especially in light of bottlenecks due to high demand for services and long waitlists. In the 1960s and 1970s, many children with MBD underwent EEG and neurologic evaluations that were often only minimally helpful in final diagnosis and management. Recent practice guidelines aimed at children with neurodevelopmental concerns have recommended widespread application of neuroimaging, genetic testing, and cardiovascular monitoring for stimulant medications, among other evaluations. Can we start to temper caution and a desire for thoroughness with stewardship of resources—or does one size have to fit all?

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Reference

1. Holmes AV, Long M, Stallworth J. We can teach how to bend the cost curve: lessons in pediatric high-value health care. *Pediatrics* 2017;139:e20164016.