

**19** ALCOHOL USE AMONG LOWER SOCIOECONOMIC STATUS HIGH SCHOOL STUDENTS. Mark I. Singer (sponsored by Katherine King), Case Western Reserve University School of Medicine, Cleveland Metropolitan General Hospital, Department of Pediatrics, Cleveland, Ohio.

This study investigated patterns of alcohol use and attitudes towards drinking among lower SES high school students. A pre-tested, 28-item self-administered questionnaire, specially constructed for this study's population, was distributed at two Cleveland high schools. Of the 1,547 students present the day of this study, 1,096 satisfactorily completed the questionnaire. 49% of the final sample were male, 51% female; 71% were black, 23% white, 6% other;  $\bar{X}$  age=16.7 yrs. Convergent validity estimates ranged from .51 to .82 ( $p < .0001$ ). Approximately 15% of students who had ever used alcohol reported taking their first full drink at 9 yrs. of age or younger. About 1 in 5 students indicated being drunk at least 3 times within the past 2 mos. However, only 1% of respondents reported their drinking posed a significant problem for them. Reliable correlations ( $p < .001$ ) were achieved between the number of times drunk and number of drinking friends (.39), positive attitudes towards drinking (.47), number of reasons for drinking (.43), age of first drink (-.28), parental drinking patterns (.20) and religiosity (-.27). A multiple regression using 6 independent variables accounted for 46% of the variance in reported drunkenness ( $F=90.50; p < .001$ ). The results suggest unacceptably high levels of alcohol misuse (20%) in this study's sample and that screening efforts with adolescent populations should not depend upon self-reports of drinking problems (1%) to identify alcohol abusing youth.

**20** MATERNAL PREPREGNANCY WEIGHT. Catherine Stevens-Simon, Elizabeth R. McAnarney, Molly P. Coulter, University of Rochester Medical Center, Department of Pediatrics, Rochester, New York.

The accurate measurement of maternal prepregnancy weight is critical since it is used to calculate gestational weight gain and to study the relationship between maternal body size, gestational weight gain, and infant birthweight. The prepregnancy weights recorded in prenatal records are usually historical information obtained by patient interview. The accuracy of this recall information is questionable. This study compares the accuracy of the historical prepregnancy weight, reported by a group of 66 young women ranging in age from 13 years to 17 years 7 months, to the actual prepregnancy weight recorded in the medical record by health professionals 6 months before to 2 weeks after the last menstrual period (LMP). Information concerning historical and actual prepregnancy weight was obtained by review of 140 medical records. Simple correlations and linear regression analysis were used to determine a correlation between historical and actual prepregnancy weight of 0.97. The significance of this correlation was not altered by controlling for maternal age, site of prenatal care, number of prenatal visits prior to LMP, or proximity of the last visit to the LMP. A tendency for heavy girls to underestimate their prepregnancy weight was noted. These findings suggest that as a group, adolescents in Rochester, New York who have an identifiable source of medical care, are able to accurately estimate their prepregnancy weight.

**21** TIMING OF ADRENARCHE AND GONADARCHE AND PSYCHOLOGICAL ADJUSTMENT IN NORMAL ADOLESCENTS. Elizabeth J. Susman, Editha D. Nottelmann, Galé E. Inoff, D. Lynn Loriaux, Gordon B. Cutler, Jr., George P. Chrousos, Nat'l. Inst. of Mental Health & Nat'l. Inst. of Child Health & Human Devel., Bethesda, MD (Spon. by Arthur S. Levine).

The study examined the relationship of timing of adrenarche and gonadarche and emotional problems in early adolescence. The participants were 9- to 14-year-old boys ( $n=57$ ) and girls ( $n=51$ ) enrolled in a longitudinal study. Assessments of physical development consisted of pubertal staging according to Tanner and plasma determinations of luteinizing hormone, follicle stimulating hormone, testosterone, estradiol, dehydroepiandrosterone, dehydroepiandrosterone sulfate, and androstenedione. We used two scales, Psychopathology and Emotional Tone (depressed mood), both from the Offer Self-Image Inventory for Adolescents, to evaluate our volunteers. Psychopathology and depressed mood scores were (a) higher for boys with high-for-age adrenal androgen levels ( $p=.01, p=.02$ ) and (b) lower for boys with high-for-age testosterone/estradiol levels ( $p=.02, p=.03$ ). Psychopathology and depressed mood scores were higher for girls with high-for-age gonadotropins ( $p=.01, p=.01$ ). However, there were no relationships for girls between the psychopathology or depressed mood scores and the adrenal androgen or estradiol levels. Thus, the timing of adrenarche and gonadarche may be an important factor in the development of adjustment problems of normal adolescents. Also, adrenal androgens appear to be more important factors in boys than in girls suggesting a higher sensitivity of the male brain to androgens.

**22** INVESTIGATION OF AMBULATORY COMPLIANCE RATES FOR YOUNG PEOPLE FOLLOWING HOSPITALIZATION FOR SUICIDE ATTEMPT. Susan E. Swedo, Spon. by J. Stockman, III Northwestern University School of Medicine, Evanston Hospital, Dept. of Pediatrics.

In the forty-two month period ending July 1983, 80 youths aged 10-21 were hospitalized because of an attempted suicide. The purpose of this study is to determine the rate of follow-up for those patients who stayed in the hospital less than 48 hours. To achieve this end, we mailed questionnaires and obtained phone interviews from the admitting physicians. We received adequate data on 65 adolescents (81%). Forty-nine of these patients were released within 48 hours of admission and are included in the data analysis ( $n=49$ ).

At discharge, 36 (73%) of the patients had a clearly planned therapy program which was outlined in the chart and discussed with the family and patient prior to discharge. Of these patients, 12 (33%) obtained follow-up care. In 13 patients, no follow-up planning was documented in the chart. Of these, none received therapy. In contrast, for the 16 patients with extended (>48 hrs.) in-patient stays: 38% (6 pts.) had outlined post-discharge plans and received care; 31% (5 pts.) had outlined post-discharge plans but didn't receive care; 25% (4 pts.) did not have outlined plans and did not receive care; and 1 patient (6%) did not have outlined discharge plans but received care.

In summary, effective discharge planning was of major import in determining patient compliance. The discussion will focus on the importance of the admitting physician making a precise and acceptable post-discharge plan and communicating this clearly.

**23** WEIGHT CONTROL METHODS AND DISTORTED BODY IMAGE IN HIGH SCHOOL WRESTLERS. Elizabeth R. Woods and Claire D. Wilson (Sponsored by Warren Grupe), Children's Hospital, Harvard Medical School, Boston, MA.

Severe weight control methods used by high school wrestlers has caused concerns for the wrestlers' growth and performance. To determine the prevalence of utilizing weight control methods, wrestlers and control athletes were studied at a private boarding school. Questionnaires and measurements (height, weight, and skin fold thicknesses) were collected over 2 years. Wrestlers ( $n=49$ ) were compared to a control group of competitive and non-competitive athletes during the same season: squash players ( $n=20$ ) and jogging/fitness students ( $n=38$ ).

The wrestlers used more methods of weight control than did the control group: dieting ( $p=0.0002$ ), bingeing ( $p=0.026$ ), vomiting ( $p=0.046$ ), sweating ( $p < 0.0001$ ), fluid reduction to < 2 cups/day ( $p=0.0014$ ) by Fisher's Exact Test (1-tail). Fasting > 24 hrs ( $p=0.5$ ) and exercising ( $p=0.1$ ) were not significantly different in the two groups. Neither group used diuretics or laxatives during the sports season. In spite of the fact that wrestlers' percent body fats were lower than the controls ( $F=1.41, t=-2.74, p=0.0073$ ), wrestlers perceived that their ideal weight should be less than their present weight ( $F=1.95, t=-2.30, p=0.024$ ).

The prevalence of extreme methods of weight control and distorted body image documented in this study raises serious concerns about the long term consequences during a critical stage of growth and development.

**24** TRANSIENT REMISSION OF HYPERTHYROIDISM IN PREGNANCY. R.H.Wu (Spon by P. Saenger). Albert Einstein Coll. Med., Bronx-Lebanon Hosp., Dept. of Peds, Bronx, NY.

A 17 y.o. girl had remissions of Graves' disease (GD) during 2 pregnancies. In the first, T4/FT4 fell on tapazole (TAP), from 21.4 to 13.0  $\mu\text{g/dl}$  and 3.31 to 0.9  $\text{ng/dl}$  resp., in 3 mos. T4 was normal off TAP from 6 wks before (BD) to 4 mos after delivery (AD) when it was 16.7  $\mu\text{g/dl}$ ; TAP was restarted. During the second, antithyroid antimicrosomal antibodies (ATAB/AMAB) and TSH binding inhibiting immunoglobulin (Nichols, TBII) were also measured (below). T4, FT4 and T3 were normal off TAP for 4 mos BD to 5 mos AD when T4 was 13.9  $\mu\text{g/dl}$  and T3, 270  $\text{ng/dl}$  (60% RAI uptake). ATAB was positive throughout pregnancy until 9 mos AD when it was < 1:10. AMAB fell to 1:400 4 mos AD, rising to 1:102,000 at 8 mos. TBII was normal for GD (13-16%). Fluctuations in autoimmune thyroid disease occurs in pregnancy; transient remissions are rare. This patient had 2 separate remissions late in pregnancy followed by relapses months later. AMAB changes occurred later than previously described and seemed to be timed with the second relapse. TBII and ATAB titers did not correlate with clinical disease.

Months	T4 ( $\mu\text{g/dl}$ )	FT4/T3 ( $\text{ng/dl}$ )	TAP ( $\text{mg/dl}$ )	ATAB	AMAB	TBII
11 BD	19.9	---	354	30	---	---
6 BD	13.5	1.0/224	20	1:32	1:6400	---
DELIV	10.7	2.4/180	0	1:64	1:6400	---
1 AD	8.5	2.3/157	0	1:64	1:6400	16.5%
4 AD	13.7	---	235	0	1:76	1:400 13.1%
5 AD	13.9	3.4/270	10	1:64	1:102000	15.8%
9 AD	15.4	---	232	10	1:10	1:25600 14.4%

NT:T4 4-10.8; FT4 1.3-3.8; T3 80-220; ATAB < 10; AMAB < 100; TBII 10-100