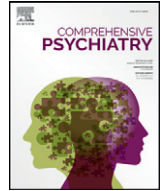


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Assessing cognition in children with prenatal methamphetamine exposure in South Africa

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We thank Jilani and Torres [1] for their interest in our paper on cognitive outcomes in prenatal methamphetamine exposed (PME) children [2]. We are grateful for their view that our data add diversity to the existing literature; indeed this is the first study assessing cognition of children with PME outside of the USA. They note a number of limitations to our work, as did we in the initial publication, and this correspondence provides the opportunity to discuss specific questions in more depth.

First, there is the question of how data were collected; in particular, the design was retrospective and not all informants were parents. As noted in our paper, we fully agree that a prospective design is ideal. That said, this requires substantive resources, which are more difficult to obtain in a LMIC context. Further, the timeline follow-back method that we employed is currently the state of the art approach in retrospective studies of substance use [3]. Restricting informants to parents in our setting, where most primary caretakers of children with PME are not biological parents [4], would lead to an underpowered and non-representative sample.

Second, there is the question of the relevance of our cognitive data; in particular, were our measures culturally relevant and comparable with normative data? The Kaufman Assessment Battery for Children version 2 (K-ABC II) and Beery Developmental Test of Visual-Motor Integration (Beery VMI) have been used widely in our setting, with evidence of validity [5–7]. As noted, we used the set of K-ABC II subtests that, with one exception, constitute the Nonverbal Scale, so permitting valid assessment of children with limited English proficiency. While we agree that local normative data are needed, in the absence of these, we compared the PME group with unexposed controls from the same environment. We took care to place test scores in light of contextual factors that may lead to lower performance on some items. Further, scaled scores for unexposed controls on the K-ABC II and the Beery VMI were comparable to normative scaled scores of the test developers, particularly in light of education level of mothers in our sample for K-ABC II scores [8,9].

Third, there is the question of whether a hypothesis of a link between PME and cognitive dysfunction should be made. Jilani and Torres [1] argue that given multiple confounders, such an hypothesis is overly simplistic.

However, given that methamphetamine has significant psychotropic effects, that animal models of PME show neuronal damage and cognitive deficits, and that studies that adjust for confounders have found adverse maternal and child outcomes, our view is that such a hypothesis is worth testing. We noted the presence of an association between PME and cognitive outcomes in our data, and indicated that PME may be a contributor to these findings. We agree with Jilani and Torres [1] that caution is required when interpreting data, and trust that the tone of our discussion was indeed cautious, and did not make overreaching causal inferences. What is certainly needed, the field agrees, is further research using best practice methods, but more importantly evidence-based policies to address methamphetamine use in vulnerable communities.

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