

agnostic teams can be “geographic, regional or virtual,” and they can “accept referrals from distant communities and carry out an evaluation using telemedicine.” These teams may perform assessments in series or in parallel (in other words, over a period of days, weeks or months or during a concurrent, shared clinical encounter). Furthermore, “the core team may vary according to the specific context.”<sup>1</sup>

We agree that the assessment of brain injury outlined for the neurobehavioural assessment in recommendation 3.1 of the supplement is comprehensive. The brain injury diagnosis employs standardized and internationally accepted neuropsychologic measures that identify brain dysfunction. Our recommendation is based on evidence that this more robust approach avoids misdiagnosis or overattribution of the observed central nervous system deficits to alcohol exposure. To date, no “phenotype” for the FASD brain has been validated; hence, a comprehensive neuropsychologic assessment of brain function is required to establish alcohol-related brain injury. Substantial deficiencies or discrepancies across multiple areas of brain performance are associated with a 5- to 10-fold increase in the risk of structural or neurologic damage.<sup>3</sup> In comparison with the costs of current neuroimaging techniques (including MRI and PET), this approach is also more cost-effective.

We disagree with Keith Goulden that “none of these children will meet the diagnostic criteria [for FASD] for [educational] funding.” By adhering to these guidelines we are able to accomplish reliable and consistent diagnosis.

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**Correction**

The DOI attached to recent English<sup>1</sup> and French<sup>2</sup> editorials should have read 10.1503/cmaj.051229 and 10.1503/cmaj.051230, respectively.

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