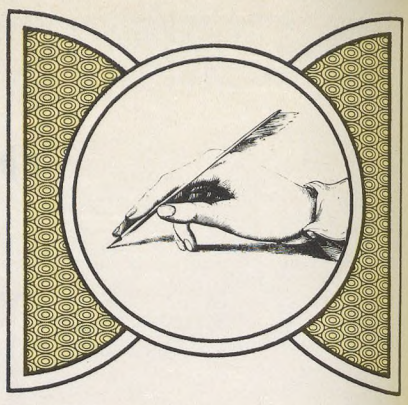
Letters to the Editor



Treatment of Whiplash Injury

To The Editor:

I read with interest the article on cervical myelopathy secondary to cervical spondylosis by Dr. Donald Peterson, *(J Fam Pract 4:233, 1977).* It is a timely article in that one of the etiological causes, as he mentions in his article, is remote head and neck trauma, and the incidence of so-called whiplash injuries to the neck is increasing. Dr. James Cyriax, of London, England, who is visiting Professor in Orthopedic Medicine to the University of Rochester, Rochester, New York, feels strongly that in whiplash injuries of the neck, one of the problems is a cervical disc derangement with a protrusion of the disc fragment posteriorly, with impingement on, and stretching of, the posterior longitudinal ligament. For years, he has strongly recommended the manipulative reduction of this fragment of cervical disc, as *early* as possible after it has been detected, to allow a repositioning of the posterior longitudinal ligament in its normal place, and a reduction of the tendency to develop osteophytes at this location. As you know, osteophytes tend to grow out to fill the space between the bone and the ligament, and if no fragment is exerting pressure and stretching this ligament then, in theory, the osteophyte should not occur.

I would recommend that anyone who is interested in whiplash injury read Dr. Cyriax' *Textbook of Orthopedic Medicine (Baltimore, Williams & Wilkins, 1975)* with particular reference to his management of whiplash injuries on pages 142-144 of the sixth edition. I have been using his techniques now for two or three years, and find that early reduction of the fragment of disc restores full range of movement to the whiplashed neck.

Again, congratulations on this interesting article, and perhaps something in the way of preventive medicine may be done to forestall the increasing frequency of this cervical myelopathy.

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Family-Oriented Medical Record

To The Editor:

The recent article by Drs. NT Grace, EM Neal, CE Wellock, et al, regarding a reorientation of the problem-

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oriented medical record for family practice *(J Fam Pract 4:91, 1977)* was quite interesting. We have tried a variety of formats and, while we can see certain advantages to the system presented, we note several significant problems.

Generally speaking, a "practical medical record" should do more than simply record. It should allow for quick recording and recovery of information in an organized manner and remind the physician of health-maintenance timing as well as allow for individual flexibility. Too many sheets of paper clutter the chart and frustrate the physician and, therefore, I would make the following specific suggestions:

1. Family Problem List:
   a. Allow for a greater number of problems, with differentiation between chronic and short term types;
   b. Allow for enlargement of one individual problem list without having to change entire sheet (paste-ons, etc);
   c. Provide a place for date of onset and date of resolution for each problem.
2. Family Information:
   a. Should have some definite place for familial diseases;
   b. Should have room for changes in phone number and address;
   c. Provide for social history (ETOH, cigarettes, stress, etc) here, or on individual data sheet.
3. Individual Data Sheet:
   a. Continuing medication chart should allow for changes in dosage or frequency of medications;
   b. Immunization sheet gives no indication of when these should be done;
   c. No indication is made for when other screening measures should be done, and no mention is made of prophylactic counseling.
4. Physiological Data Sheets
   a. These should be flexible and allow for individual or family orientation. How many patients have most of these tests done, or have repeats on tests such as IVP, barium enema, pulmonary function tests, etc? These should be more than just another place to record data, and should help organize and simplify the patients' care.
   b. This would be a good place to provide for recommended preventive maintenance.

I think the concept of a family-oriented record is an interesting and viable one, and I thank you for sharing it with us.

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The above letter was referred to Dr. Grace who responds as follows:

As we mentioned in our article, the family-oriented medical record as used in our practice is not in its ultimate form but is rather in a state of evolution. Its major concepts must be adapted to the individual practice of the family physician. The ideas that Dr Ivey presents in his letter are good ones, and each point that he raises has been considered by us in the development of our record to its present state. Obviously, implementation of his ideas would result in a slightly different format than ours.

This is the value of presenting ideas in the Journal – it gives impetus to practicing physicians selecting and adapting ideas to the needs of their own practice. The most important concept that we wanted to present was that of the *Family Problem List,* where both individual problems and problems of the family as a whole are grouped. This has proved to be of great practical value, and we look forward to seeing further adaptation of this idea by other family-oriented physicians.

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