Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

The First Year in Undergraduate Medical Education

To the Editor:

The recent article "Insecurity in Medical Education: A Preventable Problem?" by John P. Geyman, MD (*J Fam Pract 6:229, 1978*), was very insightful on the problem of current *relevant* medical education. We would like to inform your readers of the first-year program at Southern Illinois University School of Medicine. The first year (Sequence I) of the three-year program is intimately structured around the ideals suggested by Dr. Geyman to "reorient medical education." Sequence I provides a prototype for relevant medical education, particularly as it pertains to the broader specialties in primary care.

Sequence I at Southern Illinois University is based in Carbondale, Illinois. Carbondale is the center of the rural southern portion of Illinois. The first year is not affiliated with a university medical center or a large teaching hospital, but rather with a small community hospital and clinic. This creates a strong attachment between community and curriculum. Such an attachment enables first year medical students to appreciate and take part in the varied aspects of primary care within a community.

Sequence I is novel in other important respects. The curriculum is designed around organ systems. Self-learning and competency-based tests are emphasized. The organ "block" is divided into relevant clinical "problem units." These problem units deal with common clinical situations facing physicians in practice. For instance, the neuroscience block contains problem units such as headache, changes in sensation, and bowel and bladder dysfunction. Each problem unit is similarly broken down into "modules." Modules cover the appropriate basic science disciplines relevant to the particular problem unit. This organ-system, clinical-application approach maximizes integration of the basic science curriculum with clinical practice. Further emphasis on clinical problem solving is shown in frequent tests, usually centering on a clinical case problem.

To better prepare first year students for primary care practice, Sequence I contains a strong medical humanities program. This program provides first year students with insight, both of a practical and a philosophical nature, into problems facing primary care physicians such as family physicians. Some of the humanities activities have included:

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1. A discussion of medical confidentiality with a practicing psychiatrist and a sexual behavior researcher.
2. A panel discussion of problem pregnancies consisting of women who had terminated pregnancies or followed through with them to term.
3. Small group discussions on the ethics of patient consent, psychosurgery, behavior modification, and social aspects of primary care.
4. A panel discussion on organ transplant and kidney dialysis composed of a kidney donor, his wife, and a dialysis patient on a transplant waiting list.

These activities expose the student to the varied humanitarian aspects of primary care.

To conclude, we hope we have expressed some of the outstanding changes Southern Illinois University has made in traditional first year medical education.

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Hyperlipidemia in Children

To the Editor:

Though one may disagree with the ultimate usefulness of early identification and intervention in hyperlipidemia, the article "Cholesterol in Preteen Children of Parents with Premature Coronary Disease" (*Gross H, Caplan C: J Fam Pract 6:495, 1978*) is important to family medicine. A family physician could have easily done this study in his practice, and such research is vital for elucidating the unique potential contributions of office investigation. Also, studies such as this demonstrate a unique role in patient care—concern for and contact with whole family units. Who else but family physicians could identify familial risk patterns, diagnose family members across age barriers, and treat comprehensively and longitudinally, childhood through adulthood? Special offerings of family physicians are continually recognized.

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Management of Adolescent Pregnancy

To the Editor:

I enjoyed the discussion of "Adolescent Pregnancy" in Family Practice Grand Rounds (*Miller PJ, Choquette J, Kirkpatrick PT, et al: J Fam Pract 5:859, 1977*). I appreciated the team approach to this multifaceted problem, but I think some additional comments are necessary.

Dr. Miller indicated that complications can be prevented by remembering three things (manual pelvimetry, roll-over test after 20th week, and observation of diastolic blood pressure for a rise of 20 mmHg). I think it would be best stated that you may anticipate possible complications by remembering those three things. I don't think we have a way at this time of preventing pregnancy-induced hypertension.

The roll-over test (ROT), usually done between the 28th and 32nd week, does separate nulliparous normotensive pregnant women into two groups: a group at low risk of developing hypertension and a group at high risk.[1] A more rapid (2 minute) ROT has now been reported and is apparently accurate.[2]

Observing for a 20 mmHg rise in

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diastolic blood pressure may not be sensitive enough in detecting pregnancy-induced hypertension early. As early as the 17th week of gestation, a high-risk group may be identified by their blood pressures being closer to the normal nonpregnant blood pressures. Most pregnant women are relatively hypotensive early in pregnancy. A blood pressure above 110/75 mmHg sitting, or 100/65 mmHg in the left lateral position at 17 to 20 weeks of gestation is suspiciously high and would require close observation.[3]

I think the comments about management of the patient who develops hypertension imply that simple hospitalization and observation will result in a good outcome. The only effective therapeutic course for the treatment of pregnancy-induced hypertension is evacuation of the uterine contents. It may be better to err on the side of early delivery than to procrastinate and face potential maternal mortality or morbidity.

The study cited for conservative management of hypertension has a unit used exclusively for the management of high-risk pregnancies. (Such a unit is not available everywhere.) That study also excluded any patient with a diastolic blood pressure >110 mmHg and significant proteinuria. All patients are not to be simply monitored conservatively. Additionally, Hauth et al[4] stated that ambulation ad lib in the hospital was very sedentary compared to usual outpatient activities.

It should be noted that of those patients managed conservatively by Hauth et al,[4] 89 percent developed a recurrence of hypertension (42 percent before labor and 47 percent during labor). All patients were delivered immediately if there was:

1. rapid weight gain
2. a decrease in creatinine clearance
3. the appearance of significant proteinuria
4. clinical and/or sonographic evidence of fetal growth retardation, or
5. development of severe headache or scotomata.

Lee's[5] use of the nonstress test would be worthwhile in evaluating the high-risk adolescent. Also, the acoustic stimulation nonstress test may offer a more rapid noninvasive method of assessing fetal well-being.[6]

Additionally, the discussion of the nutritional needs of the pregnant adolescent did not discuss the assessment of initial weight (ie, under ideal weight) or the need for specific weight gain (>20 pounds) during pregnancy.[7]

I believe the management of the pregnant adolescent is a little more complex than is implied in the article.

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