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.

Skin Manifestations of Diabetes

To the Editor:

I enjoyed reading Dr. Osment's excellent article recently published in The Journal, "Dermatoses of the Scalp" (J Fam Pract 8:1217, 1979). I was reminded of a patient whose presentation and clinical course is very pertinent to the substance of this article.

In June 1978, a 64-year-old house wife came to my office with a large, multiloculated pustular eruption covering nearly the entire left temporal region of her scalp. Two months earlier a similar but smaller lesion had appeared in the same area but had resolved spontaneously. Cultures of the exudate revealed Staphylococcus aureus, coagulase positive. Treatment consisted of frequent incision and drainage procedures and an oral cephalosporin. The patient then left to accompany her husband on an out-of-state business trip, but I instructed her to obtain local medical consultation every three to four days. She complied and returned home in six weeks well-healed and full of praise for her treatment while en route.

Our next encounter was January 8, 1979, when she presented with another skin abscess covering the right maxilla and preauricular areas of the face. She gradually improved with identical treatment, but this time I felt obligated to check for underlying systemic disease. A fasting blood glucose level was 303 mg/100 ml, and a two-hour postprandial glucose level was 364 mg/100 ml. She was placed on strict dietary control and extensive diabetic counseling. To date she has not returned for the problems of pyoderma or folliculitis.

In light of this experience, I would like to echo Dr. Osment's remarks that the scalp participates in many systemic disorders, frequently as the initial site of involvement. Furthermore, I, along with several other physicians, was perhaps too complacent in not suspecting a more generalized process at the onset of her seemingly well-localized problem.

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Middle-Age Occupational Spectrum

To the Editor:

Taking issue with a single point in Dr. Medalie's otherwise excellent and thorough article, "The Family Life Cycle and Its Implications for Family Practice," in the

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July issue of *The Journal of Family Practice (9: 47, 1979)* seemed at first petty carping, yet reflecting on it, I feel the omission of one point in the Middle-Age Occupational Spectrum (Table 2) is sufficiently important to warrant comment.

Dr. Medalie lists four positions in the Spectrum: No work, no hope, welfare; Adjusting to a new occupation (until recently, a relatively uncommon situation for the middle-aged); Working, but will never reach top or expectations; and Reached(ing) the top. This list omits one position at least equally important for the person's overall health: Content in stable, mid-level occupational status. In contrast to the four positions listed which all have varying degrees of stress associated with them, either intrinsically or for unfulfilled aspirations, this position would have a salutary effect on health. Some people, an increasing number recently I suspect, are quite content in mid-level positions doing what they can do well, and never aspire to anything higher.

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Sudden Death of Married Couple

To the Editor:

I was fascinated by the article "Sudden Cardiac Death in a Husband and Wife" by Drs. Michael and Arthur Miller *(J Fam Pract 9:503, 1979)*, relating psychologic factors and sudden death. May I add two personal clinical examples, relating psychologic factors to sudden death in one case, and myocardial infarction in a husband and wife in the other.

Example 1: Nurse D., working with me in my practice, received a telephone call saying that her only brother, a soldier, had been accidentally killed. In addition to her own shock, she kept saying, "What is going to happen to my father?" Her father, aged 60 and an active dermatologist with moderate hypertension for which he was receiving treatment, had a very close relationship with his only son. Nurse D. notified her mother and together they broke the news to the father. The latter took the news very badly and within a few hours, went into coma and died. He and his son were buried in graves alongside each other at a joint service the next day. No autopsy was performed so I cannot state the cause of death with certainty.

Example 2: Family L. were an elderly couple both in their early 70s who had been patients of mine for a number of years. They were delightful people with a very warm relationship. Both had osteoarthritis; she was slightly obese and had systolic hypertension, while he had prostatic hypertrophy, a total serum cholesterol of nearly 300 mg/100 ml, and developing cataracts.

One night I was called to their home because Mrs. L. was having severe chest pain. I diagnosed myocardial infarction and sent her to the hospital. Mr. L. accompanied her in the ambulance. In the Emergency Room, Mrs. L. had a cardiac arrest and the resident who saw her shouted for the emergency apparatus saying something about her "heart had stopped." Mr. L., who was standing at a little distance from her, thought that she had died, and fainted. Upon reviving him, the nurse noticed that his

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pulse was very irregular and he began to complain of chest discomfort. He was admitted, together with his wife (who had been resuscitated) to the acute ward where he, like her, developed definite ECG signs of acute myocardial infarction. Unlike the Miller case, this couple recovered and returned home.

It is difficult for me to believe that experienced clinicians still question the association of emotional factors and acute illness, but if so, let them add these two clinical examples to their collections.

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Preventive Medicine in Family Practice

To the Editor:

I read with great anticipation *The Journal of Family Practice* Preventive Medicine issue *(Vol 9, No. 1, 1979)*. I particularly looked forward to in-depth articles that would integrate concepts of health and disease. However, I was disappointed to find the articles included in the issue concentrating on *pathology* and the traditional approach to *disease* prevention.

Dr. Berg focused upon traditional measures of *disease* and prevention thereof. While this perspective is accurate, it is by no means a complete picture. By limiting the perspective to traditionally quantifiable, measurable factors, many potentially important factors affecting health are not considered. Particularly important factors to consider include measures of the influence of the family on the health of its members. The family is a primary environmental factor in the lives of its members and the lack of adequate means to measure its influence does not reduce its importance.

Dr. Medalie provided a refined life-cycle model which is useful in anticipating problems which might occur among family members. While this model gives a significantly more comprehensive view of family medicine, many assumptions are made, and no simple, concrete method is included for its application in clinical practice or for the solution of the problems identified.

Dr. Thompson provided the HMO approach. I appreciate his recognition of at least one important family member, the parent of the well child. Dr. Grove identified the work place as important environmentally and shows us some of his methods of altering measurable risk factors of *disease*. Dr. Sloane showed us his way of remembering what *disease* screening to undertake and when to do it. Dr. Schuman alluded to the unique role of the family physician as a practitioner and member of the community in disease prevention. Again, while these are all important aspects of family medicine, they are predominately *disease* oriented.

From my perspective as a clinican and teacher of family medicine, I believe that the prevention, detection, and treatment of pathology or disease are only a part of the practice of family medicine (this orientation is our legacy from the longer established specialties). Many patient problems that have no well-defined relationship to pathology or its prevention face the family phy-

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sician daily. These were, for the most part, overlooked in the preventive medicine issue. The prevention of nonpathological problems was not addressed adequately even though this is a major consideration in practice. The role of *nonpathological* problems in the natural history of disease was not discussed. No simple framework was provided with which to integrate the management of health and disease in a busy practice. The role of the family in disease prevention and health maintenance was not discussed.

It is important that we acknowledge our traditional enchantment with the measurement of pathology. We have become preoccupied with the easily obtained numbers derived therefrom. It is time for us in family medicine to develop and employ measures of *health* and *nonpathological* problems in order to further define our specialty and improve our practices.

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To the Editor:

In the July 1979 issue of *The Journal of Family Practice,* Grove et al *(Grove DA, Reed RW, Miller LC: A health promotion program in a corporate setting. J Fam Pract 9:83, 1979)* have reported impressive results from their experience with a health promotion program in a corporate setting. The results include significant weight loss and reduction in blood pressure and cholesterol levels. There are, however, three points which deserve mentioning as cautions for the reader against making hasty conclusions concerning the efficacy of such a program.

This is a one group pretest-post-test study. Therefore, concluding that the changes in the parameters measured are attributable to the program is subject to many biases. These include both internal biases (eg, changes in instrumentation accuracy, systematic variation in the parameters due to the passage of time) and external biases (eg, sociocultural changes with time).

A second point lies in the authors' lack of attention to nonparticipants of the program. What were the characteristics of those persons who (1) returned the questionnaire (54 percent) vs those who did not return the questionnaire, and (2) what were the characteristics of those participating in the intervention vs the nonparticipants? These comparisons are important to determine if the program is reaching those who need it most (those at high risk). Other studies indicate that primary prevention programs are used most frequently by those who need them least.[1]

Finally, the authors note that caution must be observed to avoid expectations for rapid change. Similarly, it should be noted that their observations are short-term in nature and that only long-term positive results will bear the "proof of the pudding" . . . a decline in the incidence of disease greater in magnitude than a comparison group.

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Reference

1. Wilhelmsen L: A comparison between participants and non-participants in a primary preventive trial. J Chron Dis 29:331, 1976