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.

Education of Medical Students

To the Editor:

The Association of American Medical Colleges has embarked on a project to appraise the status of The General Professional Education of the Physician and College Preparation for Medicine. An 18-member panel, chaired by Dr. Steven Muller, President of The Johns Hopkins University, after its first year of deliberation, has identified four concerns that will challenge faculties responsible for selecting and educating medical students:

- The rapid growth of knowledge applicable to the care of patients and the treatment of disease
- The ascendency of complex technology and procedures in the diagnosis and treatment of patients with overt or potential disease
- The coalescence of physicians, other health professionals, and hospitals into complex systems, which is paralleled by a concentration of the financial support for medical care in government and private agencies
- The mounting evidence that physicians are having difficulty coping with the rapid progress in medical care and in adapting to demands placed upon them by their patients and by the profession

To gather information and ideas, the panel is holding regional hearings where faculty, students, practicing physicians and other individuals interested in and concerned about medical education can express their views. The hearing schedule is:

University of Texas, Houston, February 24-25, 1983
Northwestern University, Chicago, March 24-25
New York Academy of Medicine, May 5-6, 1983

For more information, contact Mary H. Littlemeyer, Project Coordinator, Association of American Medical Colleges, 1 Dupont Circle, Washington, DC 20036.

August G. Swanson, MD
Director,
Department of Academic Affairs
Association of
American Medical Colleges
Washington, DC

Depression: Symptom or Syndrome?

To the Editor:

The recent response to the position taken in our letter, "Use of Depression Inventories" *(J Fam Pract 14:454, 1982)*, by Seller, Blascovich, and Lenkei *(J Fam Pract 14:456, 1982)* apparently misunderstands our main concern and perpetuates a pervasive clinical and research error in family medicine that we believe should be remedied.

We do not find fault with the use of either Beck's Depression Inventory[1] or our own[2] as measures of severity of depressive symptomatology. Both instruments are sound, although the short forms of both may be preferable in family medicine settings.

What Seller et al[3] and other authors in family medicine have failed to recognize is the difference between depression as a symptom and depression as a syndrome or diagnosis. This lack of conceptual clarity is analagous to assuming that every patient with symptoms of pharyngitis has strep throat.

No existing depression inventory can make a diagnosis of a depressive syndrome, and Beck[1] has appropriately cautioned readers that his inventory should be used for screening purposes. It therefore can be useful in detecting patients who may fulfill the criteria for a diagnosis of depression, but it alone cannot make a diagnosis. For example, neither instrument documents the two-week duration of symptoms required in standard psychiatric diagnosis, nor do they question bizarre behavior or mood-incongruent delusions or hallucinations, both of which are key factors in differential diagnosis.

Schizophrenic patients often score very high on symptoms like social withdrawal, distortion of body image, irritability, and indecision. Beck's inventory would then indicate severe depressive symptomatology, despite the ab-

sence of a depressive syndrome. When physicians are prepared to prescribe penicillin for every sore throat, then it will be time to prescribe antidepressants for everyone scoring high on a depression inventory.

Sheila M. Berndt, MD
Illinois Masonic Hospital
Family Practice Residency Program
and
David J. Berndt, PhD
Department of Psychiatry
Michael Reese Hospital
Chicago, Illinois

References

1. Beck AT, Ward CH, Mendelson M, et al: An inventory for measuring depression. Arch Gen Psychiatry 4:561, 1961
2. Berndt DJ, Petzel T, Berndt SM: Development and initial evaluation of a multiscore depression inventory. J Pers Assess 44:396, 1980
3. Seller RH, Blascovich J, Lenkei E: Influence of stereotypes in the diagnosis of depression by family practice residents. J Fam Pract 12:849, 1981

Alcohol Education for Family Practice Residents

To the Editor:

The disease of alcoholism is an important part of the family physician's practice experience, both in the hospital and in the office. Attitudes, especially negative ones, toward the alcoholic patient cause the physician considerable difficulty in effectively treating his patients. Many studies of family physician experiences show minimal awareness of the disease of alcoholism and suggest that when alcoholics are treated by family physicians, their conditions may be significantly underdiagnosed.[1]

Studies of attitude development suggest that physicians' negative attitudes toward the alcoholic and alcoholism begin early in the medical education and generally worsen as experience with alcoholics becomes more burdensome.[1] Recognition of the disease process of alcoholism has not permeated the physician's view of this disorder. Several studies found that courses in medical school tended to hamper the physician's total view of his alcoholic patients and in fact increased negative attitudes toward alcoholics.[1-3] Chavetz[4] many years ago felt that personal relationships were very important from the outset in determining the treatment potential for the alcoholic. A good interpersonal relationship and working together to deal with the problem produced the best chances for the physician to effectively treat the alcoholic. If positive relationships did not develop, no positive treatment could be developed for the alcoholic.[4]

Given this problem, a special program was developed at the Sundown M Alcoholism Treatment Center in White Swan, Washington. This program was designed not only to change attitudes of family physicians but also to have them experience a close relationship with recovering alcoholics. These physicians were given an attitude questionnaire before and after their program at Sundown to see if the program could effectively change their opinions regarding alcoholics and alcoholism.

The program consisted of four 7-hour days at Sundown M Ranch. The family physicians were expected to follow the regular treatment program during these four days and were presented with lecture topics and engaged in large and small group discussions. They were involved on a one-to-one basis with recovering alcoholics, exposed their own views, and were exposed to the views of the recovering alcoholic. The final day of their four-day experience they were involved at the local community alcohol center, where they were exposed to outpatient education and follow-up programs with recovering alcoholics.

The results of this program showed that physicians can be well educated in the area of alcoholism. The questionnaires given before and after the experience indicated major changes in attitude. Prior to the experience the physicians believed that alcoholism was related to a personality or mental disorder; this view was changed in over 90 percent of the physicians tested. The disease concept of alcoholism was accepted, and the view that alcoholism is a moral weakness or character disorder was rejected. The belief that alcoholism is primarily a condition, affecting men and lower socioeconomic groups that has a very poor prognosis, was changed considerably. An awareness of the value of Alcoholics Anonymous also accounted for a major shift in attitude.

Sundown M's relationship with family physicians continues as a regular part of the family practice residency program. We feel this is an exciting program. It has made major changes in attitudes and education of young physicians. We would hope that this program can be instituted in other areas so that physicians can enhance their understanding of and care-giving capacity toward the alcoholic patient.

Frederick A. Montgomery, MD
Medical Director,
Sundown M Ranch
Yakima, Washington

References

1. Fisher JC, Mason R, Kelley K, et al: Physicians and alcoholics. Q J Stud Alcohol 30:7, 1973

2. Reynolds B: Attitudes of medical interns towards patients and health professionals. J Health Soc Behav 12:307, 1971

3. Wolf I, Chafetz ME, Blane HT, et al: Social factors in the diagnosis of alcoholism. Q J Stud Alcohol 26:72, 1965

4. Chavetz ME: A procedure for establishing therapeutic contact with the alcoholic. Q J Stud Alcohol 22:325, 1961

Cervical Cytology

To the Editor:

In July 1981[1] we published the results of a study comparing the adequacy of cervical cytologic preparations utilizing the standard Ayre spatula and cotton-tipped applicator with a newer extended tip spatula (Surgipath Medical). In that article it was shown that the yield of endocervical cells on cervical Pap smears was significantly greater when the extended tip spatula was used by family practice residents and faculty in the Family Practice Center of the Department of Family Medicine of the University of Cincinnati College of Medicine.

In the published study only the Ayre spatula and cotton-tipped applicator or the extended tip spatula were made available to the study group of physicians. They were not aware of the study in progress, nor were they especially trained in cervical cell harvesting. The applicance used to harvest cervical cells was used because it was, at that time, the only one available. It was found that under those circumstances 58 percent of 100 Pap smears from premenopausal women prepared from the Ayre spatula and cotton swab revealed endocervical cells. The presence of endocervical cells was used as our criterion for an adequate smear. Seventy-seven percent of 54 pairs of slides in which the extended tip spatula was used were found to have endocervical cells.

So that laboratory bias would be minimized in that study, the cytotechnologists screening the slides were not informed of the study. The chief cytotechnologist, who was involved in the study, reviewed the specially coded slides in order to verify the screening cytotechnologist interpretation. Questionable slides were further reviewed by the physician cytopathologist of the Department of Pathology. Because of the efforts to minimize use and interpretation biases, it was felt that the results obtained reflect a basic difference in the mechanical efficiency of harvesting endocervical cells by Ayre spatula and cotton swab and the extended tip spatula.

In order to further evaluate our methods and results, we continued our study of endocervical cell harvesting following the publication of our first paper on the subject. Faculty and resident colleagues in the Department of Family Medicine were apprised of the research activity and were asked to use the cervical cell harvesting appliances that they preferred to obtain gynecologic Pap smears. In the past several months we have studied 258 additional pairs of cervical Pap smears obtained from premenopausal women examined at the Family Practice Center.

One hundred pairs of slides were made with the Ayre spatula and cotton-tipped applicator and 158 from the extended tip spatula. In that group 66 percent (66/100) of the Ayre Pap smears revealed endocervical cells and again 77 percent (122/158) of the extended tip spatula slides combined endocervical cells.

In total we have studied the cervical Pap smears from 412 premenopausal women. Overall we have obtained endocervical cells in 77 percent of the extended tip spatula examinations and 62 percent of the Ayre spatula and cotton swab examinations. We feel that these findings support the concept that a spatula which can be placed within the cervical os with its surface continguous to the cervical canal is a highly effective instrument in obtaining endocervical cells for cytologic evaluation. It is our opinion that the extended tip of the spatula is much more likely to come into direct contact with the squamocolumnar junction than is the cotton-tipped applicator. The increased harvest of cells may well tend to have a salutory effect on decreasing the number of false-negative Pap smears now obtained using less thorough methods. In view of the current guidelines of the American Cancer Society for cervical cytology, this could well be an important factor for many women.

V. Franklin Colón, MD
Department of Family Medicine
and
Larry Linz
Department of Pathology and
Laboratory Medicine
University of Cincinnati
Medical Center
Cincinnati, Ohio

Reference

1. Colón VF, Linz LE: The extended tip spatula for cervical cytology. J Fam Pract 13: 37, 1981

Toxic Epidermal Necrolysis

To the Editor:

This letter reports the case of a 74-year-old black man with seven

Continued on page 231

Continued from page 224

recurrences of toxic epidermal necrolysis. *Episode 1* (1947): Without any known exposure to drugs or chemicals, the patient developed a swollen face and sloughed his skin within two days. *Episode 2* (1965): An upper respiratory tract infection was treated with penicillin. Denuded areas appeared on both upper extremities. Oral corticosteroids helped to achieve complete recovery. *Episode 3* (1967): Self-treatment with penicillin and aspirin for a toothache resulted in intense pruritus and multiple bullae with denuded areas. A skin biopsy showed full thickness epidermal necrolysis with underlying early epidermal regeneration. *Episode 4* (1970): The day following a left cataract extraction, multiple bullae appeared, and topical steroids were given with slow improvement. *Episode 5* (1971): The postoperative course to a right cataract extraction was marked by widespread, multiple vesicles with resulting denuded areas. Topical steroids were used with slow healing. *Episode 6* (1973): Within one day after a temporal artery biopsy, an intensely pruritic, diffuse papular eruption appeared with areas of sloughing. Oral steroids were used. In 1974, oral steroids were given before a traumatized right eye was repaired, and only mild pruritus developed. *Episode 7* (1977): The day after a bilateral orchiectomy was performed because of prostatic carcinoma, extensive sloughing appeared. A skin biopsy showed extensive epidermal necrosis; pemphigus antibody was negative. Oral prednisone was tapered as healing progressed.

In a review of the English medical literature,[1-9] only one other patient survived seven recurrences.[7] In Rowell and Thompson's 1961 review of 27 patients, 6 had had recurrences.[8] However, no multiple recurrences were cited. The high recurrence rate is unusual in that 25 to 50 percent of patients succumb to the initial episode. A careful analysis of the drugs given perioperatively (episodes 4-7) indicate that barbiturates were the most consistently given drug. Barbiturates have long been known to produce toxic epidermal necrolysis.[9]

The most important lesson to draw from these events is the importance of old records. Every resident, intern, and practicing physician dreads the thought of reviewing the records of a multiproblem patient during the course of the initial workup. In 1974 preoperative steroids and careful attention to all drugs given thwarted the manifestation of toxic epidermal necrolysis. Analysis of the patient's old records alerted the staff physicians. How many times has the careful review, albeit tedious, of old records revealed an important, interesting finding that had direct bearing on the outcome of the current problems!

Eric S. Miller, MD
Lincoln, Maine

References

1. Elias PM, Fritsch P, Epstein EH: Staphylococcal scalded skin syndrome: Clinical features, pathogenesis, and recent microbiological and biochemical developments. Arch Dermatol 113:207, 1977

2. Peck GL: Toxic epidermal necrolysis in a patient with a graft vs host reaction. Arch Dermatol 105:561, 1972

3. Amon RB, Dimond RL: Toxic epidermal necrolysis: Rapid differentiation between staphylococcal and drug induced disease. Arch Dermatol 111:1433, 1975

4. Arbuthnott JP: Studies of staphylococcal toxins in relation to toxic epidermal necrolysis: The scalded skin syn-

Continued on page 233

Continued from page 231

drome. Br J Dermatol 86:35, 1972
5. Elias PM, Fritsch P, Dahl MV, et al: Staphylococcal toxic epidermal necrolysis: Pathogenesis and studies on the subcellular site of exfoliation. J Invest Dermatol 65:501, 1975
6. Pearson RW: Advances in the diagnosis and treatment of blistering disease: A selected review. In Malkinson FD, Pearson RW (eds): Yearbook of Dermatology. Chicago, Year Book Medical, 1977, p 37
7. Lyell A: Toxic epidermal necrolysis: An eruption resembling scalding of the skin. Br J Dermatol 68:355, 1956
8. Rowell NR, Thompson H: Toxic epidermal necrolysis in a patient with pulmonary aspergillosis. Br J Dermatol 73: 278, 1961
9. Stuttgon G: Toxic epidermal necrolysis provoked by barbiturates. Br J Dermatol 88:291, 1973

Diuretic Induced Hypokalemia

To the Editor:

The article by Robert P. Navarro et al, "Diuretic Induced Hypokalemia in the Elderly," which appeared in the April 1982 issue *(J Fam Pract 14:685, 1982)* appears to have a major design flaw in the study that invalidates the results. The study was a retrospective chart audit of patients on four diuretics—hydrochlorothiazide, hydrochlorothiazide-triampterene, furosemide, and chlorthalidone. The study found that the potassium level did not fall below 3.0 regardless of the diuretic used and that none of the patients became symptomatic. Therefore, it was concluded that no clinical significance exists among the four diuretics in regard to production of hypokalemia.

The possible flaw in the design of the study was to apparently exclude all patients from the study who were on potassium supplements. Since all patients in the study had at least one potassium level determined, it is safe to assume that those who did develop low potassium were placed on supplements, whereas those who did not significantly drop their potassium levels were not. This study appears to look only at the latter. If this is correct, the only conclusion that can be reached from the study is that elderly patients on diuretic therapy who do not significantly decrease their potassium levels, regardless of the diuretic, do not need potassium supplements.

H.T. Milhorn, Jr, MD, PhD
Assistant Professor and Director, Research Division
Professor, Physiology and Biophysics
University of Mississippi Medical Center
Jackson, Mississippi

The preceding letter was referred to Dr. Navarro, who responds as follows:

I appreciate Dr. Milhorn's interest in our paper. However, I do not believe the possible flaw he suggests regarding study bias occurred. I apologize for the lack of clarity in the original article regarding data collection. It is true that the data was collected retrospectively. However, each patient was followed prospectively; that is, regardless of when the diuretic was started, all patients were followed from that day forward (assuming potassium supplementation was not started prophylactically prior to checking the serum potassium). If patients were eventually given potassium supplementation, they could have been included in the study prior to supplementation, and the potassium value (responsible for the institution of supplementation) would have been reported in the study.

In summary, we began collecting data on patients from the day diu-

Continued on page 235

Continued from page 233

retic therapy was started by reviewing chart notes and laboratory reports. Some subjects eventually received supplementation. However, they were included in the study if they had potassium values reported prior to receiving supplementation. Therefore, we believe patients who eventually developed "low" serum potassium were not selected out.

Robert P. Navarro, PharmD
Pharmaceutical Consultant Services
St. Paul, Minnesota

To the Editor:

I very much enjoyed the article by Robert P. Navarro et al, "Diuretic Induced Hypokalemia in the Elderly" *(J Fam Pract 14:685, 1982)*. There are several references that might be included in future work dealing with this area. Those presenting with ischemic heart disease or ventricular dysrhythmias may be a unique population deserving further study. Solomon and Cole noted an increased incidence of ventricular dysrhythmias in acute myocardial infarction patients whose plasma potassium levels were between 3.1 and 3.5 mEq/L.[1] This increased frequency of ventricular dysrhythmias was corroborated in another group of patients who did not have organic heart disease.[2]

Further work in this area might profitably focus on morbidity outcomes in elderly patients with plasma potassium values in this range.

Was this study designed to utilize serum, as opposed to plasma, potassium? As a medical technologist, I was taught that potassium is released from leukocytes and platelets during the process of clotting and retraction. Therefore plasma potassium is more stable and reproducible.

Wm. MacMillan Rodney, MD
Assistant Professor of Family Medicine
Director, UCLA Residency Program
University of California–Los Angeles
Los Angeles, California

References

1. Solomon RJ, Cole AG: Importance of potassium in patients with acute myocardial infarction. Acta Med Scand Suppl 647:87, 1981
2. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. Am J Med 70:762, 1981

Subclavian Lines and Venous Thrombosis

To the Editor:

In a recent article on subclavian lines *(Placement of subclavian lines. J Fam Pract 12:543, 1981)*, Dr. Duane S. Bietz indicated that venous thrombosis could occur after long-term usage. We have recently had a patient with subclavian vein thrombosis that developed after only 48 hours of placement.

The patient was a 52-year-old male alcoholic who experienced a gastrointestinal bleed. He had a subclavian line placement without difficulty and was discharged 72 hours after admission. He was later readmitted because of swelling of his right upper extremity. Contrast venogram revealed thrombosis of the vessels leading to the subclavian vein and multiple collaterals.

The patient was treated with anticoagulation and elevation with total resolution of his problem. Subclavian vein catheterization for diagnosis and therapy carries with it the complication of thrombosis.

Continued on page 238

Continued from page 235

This accounts for only 2 to 3 percent of all deep vein thromboses, but prevalence may be increasing because of increasing utilization of the procedure.

Van J. Stitt, Jr., MD
Director of Clinical Teaching and Curricular Activity
FAHEC Family Practice Residency Program
Fayetteville, North Carolina

Choice of Sterilization Procedure

To the Editor:

The article "The Choice of Sterilization Procedure Among Married Couples" by Markham and Frankel in the January 1982 issue *(J Fam Pract 14:27, 1982)* was quite interesting; however, there was an absence of data that would have enhanced its usefulness and perhaps altered the results and conclusions.

The sample analyzed was limited to the 86 patients (29 vasectomy and 57 tubal ligation) who returned questionnaires handed out to all patients for the two procedures. No analysis was made, however, of the patients who did not return the questionnaires. In the absence of this data, primarily demographic, one is left with an unanswered question: Are young, white, well-educated, moderately affluent, maritally stable patients most likely to return questionnaires? Although this is factitious, it does serve to make one question the validity and applicability of the conclusions beyond the small sample analyzed.

Russell L. Anderson, MD
Chairman, Department of Family Medicine
University of Alabama
University, Alabama