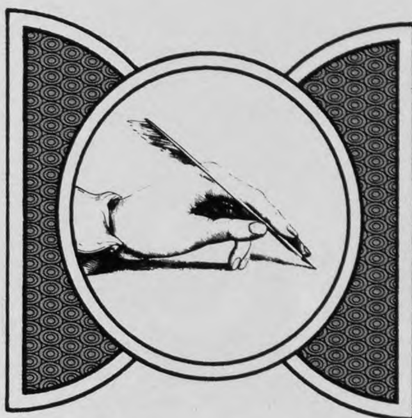
Letters to the Editor



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 Patient—Individual or Family?

To the Editor:

It appears that family medicine is now at that generative stage of maturity when many of the battles have been fought and won and the time for sophistication remains. In the literature is one such contest—that of the family.

Who and what is the family? Who is or can be the patient (the individual or the family)? Can or should the family be a patient is an issue yet to be answered. In his article in *Family Systems Medicine* (Spring 1983) Carmichael[1] raised some eyebrows when he looked at his records of ten years and concluded that the individual is the patient and not the family. Schmidt[2] suggested bringing the family in on 14 specific situations.

Certainly all would agree on the impact of illness on the family and the family's system of support in illness. I feel we are now confronted with defining the art of family medicine. Facing us are such issues as privacy, confidentiality of the individual, enmeshment in families, and loss of individual identity. If a wife has an affair and has a gonorrhea culture, does the physician discuss this with the husband? It certainly has an impact on him and their family.

I feel each situation must be looked at and decisions of care processes made on individual merit. Yes, the family may be the patient at times, but at the expense of individuality. This double-edged sword must be drawn carefully by the skilled practitioner as he or she helps carve the path of health.

Lawrence I. Silverberg, DO
West Friendship, Maryland

References

1. Carmichael L: Forty families—A search for the family in family medicine. Fam Systems Med 1(1):12, 1983
2. Schmidt DD: Family determinants of disease: Depressed lymphocyte function following the loss of a spouse. Fam Systems Med 1(1):33, 1983

Procompetition Legislation

To the Editor:

Dr. Pellegrino in the January issue *(Pellegrino ED: Procompetition legislation: The moral dilemmas of untested assumptions. J Fam Pract 16:17, 1983)* theorizes that the competitive-commercial spirit that is on the rise in our profession will eventually stultify the morals and professionalism of American medicine.

I think the author misinterprets and exaggerates the influence of sound business principles on the practice of sound medicine. The two are not mutually exclusive and should present no moral dilemmas. The responsibilities, time demands, and stresses of our profession justify the application of sound business principles to ensure that a physician receives fair compensation for his or her services. Most physicians are caring and concerned people. They are not avaricious. They may be concerned about fair fees for their time and efforts, but let's not confuse that with greed.

Legal vulnerability and high technology, with all their obvious ramifications—that's what tends to make health care expensive and morally amorphous.

Edward J. Volpintesta, MD
Bethel, Connecticut

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

Dr. Volpintesta takes me to task for conclusions I did not reach. I did not suggest that physicians were greedy or avaricious or uncaring or that they should not be compensated fairly. Nor have I suggested that efficient management of one's practice presupposes poor care.

I did assert—and re-assert—that the ethos of the marketplace and of

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Precautions: Use chlorpropamide with caution with barbiturates, in patients with Addison's disease or in those ingesting: alcohol, antibacterial sulfonamides, thiazides, phenylbutazone, salicylates, probenecid, dicoumarol or MAO inhibitors. Adequate dietary intake should be assured in all patients using Diabinese.
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HYPOGLYCEMIA, IF IT OCCURS, MAY BE PROLONGED. (SEE ADVERSE REACTIONS.) IN INSTANCES OF CONCOMITANT USE WITH INSULIN, PATIENTS SHOULD BE CAREFULLY MONITORED.
Adverse Reactions: Usually dose-related and generally respond to reduction or withdrawal of therapy. Generally transient and not of a serious nature and include anorexia, nausea, vomiting and gastrointestinal intolerance; weakness and paresthesias.
Certain untoward reactions associated with idiosyncrasy or hypersensitivity have occasionally occurred, including jaundice, skin eruptions rarely progressing to erythema multiforme and exfoliative dermatitis, and probably depression of formed elements of the blood. They occur characteristically during the first six weeks of therapy. With a few exceptions, these manifestations have been mild and readily reversible on the withdrawal of the drug. The more severe manifestations may require other therapeutic measures, including corticosteroid therapy. Diabinese should be discontinued promptly when the development of sensitivity is suspected.
Jaundice has been reported, and is usually promptly reversible on discontinuance of therapy. THE OCCURRENCE OF PROGRESSIVE ALKALINE PHOSPHATASE ELEVATION SHOULD SUGGEST THE POSSIBILITY OF INCIPIENT JAUNDICE AND CONSTITUTES AN INDICATION FOR WITHDRAWAL OF THE DRUG.
Leukopenia, thrombocytopenia and mild anemia, which occur occasionally, are generally benign and revert to normal, following cessation of the drug.
Cases of aplastic anemia and agranulocytosis, generally similar to blood dyscrasias associated with other sulfonylureas, have been reported.
BECAUSE OF THE PROLONGED HYPOGLYCEMIC ACTION OF DIABINESE, PATIENTS WHO BECOME HYPOGLYCEMIC DURING THERAPY WITH THIS DRUG REQUIRE CLOSE SUPERVISION FOR A MINIMUM PERIOD OF 3 TO 5 DAYS, during which time frequent feedings or glucose administration are essential. The anorectic patient or the profoundly hypoglycemic patient should be hospitalized.
Rare cases of phototoxic reactions have been reported. Edema associated with hyponatremia has been infrequently reported. It is usually readily reversible when medication is discontinued.
Dosage: The total daily dosage is generally taken at a single time each morning with breakfast. Occasionally, cases of gastrointestinal intolerance may be relieved by dividing the daily dosage. A LOADING OR PRIMING DOSE IS NOT NECESSARY AND SHOULD NOT BE USED. The mild to moderately severe, middle-aged, stable diabetic should be started on 250 mg daily. Because the geriatric diabetic patient appears to be more sensitive to the hypoglycemic effect of sulfonylurea drugs, older patients should be started on smaller amounts of Diabinese, in the range of 100 to 125 mg daily.
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Supply: 100 mg and 250 mg, blue, 'D'-shaped, scored tablets.
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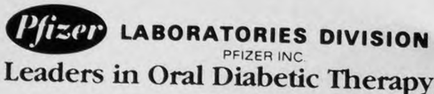

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competition can, and will, cause conflicts with traditional medical ethics. If medicine becomes primarily a business, it must follow the ethos of business—something well below the obligations demanded of those who treat the sick.

May I suggest that Dr. Volpintesta reread my piece and criticize my argument instead of defending things he holds dear, but which I did not criticize in this essay.

Edmund D. Pellegrino, MD
The Medical Center
Georgetown University
Washington, DC

Nonrotational Residency Training

To the Editor:

We were intrigued by the receipt of a recent survey from Dr. L.J. Petry, a fellow of the Duke-Watts Family Medicine Center, requesting information on the success of "nonrotational obstetrics in family practice residency programs."

First, we were interested in the use of the term *nonrotational,* since it was one of the first times we have seen that particular term used outside of our own program. The term was chosen 13 years ago by our predecessor at E.W. Sparrow Hospital, Dr. H.E. Crow, to describe our program's overall educational format. The E.W. Sparrow Hospital Family Practice Residency Program does not rotate our residents back on to other specialty inpatient services in the second and third years for their training. Rather, we have chosen to provide the bulk of their training through a nonrotational system using the Family Practice Center and our own faculty as the base.[1]

Second, we were happy to see other programs demonstrating an increased interest in establishing such a nonrotational format. We feel there are a number of benefits to it.[2] We have been using it for 13 years for all specialty areas including pediatrics, medicine, and surgery, as well as obstetrics. We have found it to be as effective for those areas as it is for obstetrics. Major benefits include the following: (1) The residents' training is as similar to practice as possible; (2) We are able to select the best teachers as consultants to supply educational input to our residents; (3) We are more independent of the other specialists, financially and educationally; (4) It serves as a stimulus to the consultant to teach, so that we continue to supply consultations to them; (5) It allows our faculty to model family practice and evaluate our own residents; (6) It enhances continuity of patient care for the residents; and (7) It helps with program funding by maintaining a large outpatient base to supply inpatient cases.

Third, we were glad to see that Dr. Petry has recognized that the Family Practice Residency Review Committee requirements do allow a variety of options in obstetrics, including a "nonrotational longitudinal obstetrics" experience. We further applaud the Residency Review Committee for allowing a continued flexibility with program formats as long as proper outcome documentation of educational experience occurs. We would also like to acknowledge the initial efforts and perseverance of Dr. H.E. Crow, who was able to establish this model as a viable educational format for resident training in family practice. We believe this model promotes the credibility of family practice as a specialty, and family physicians as teachers of our residents.

Last, we would like to extend an offer to share with other program directors any information regarding our 13 years' experience with this format.

William C. Carley, MD,
Kathleen F. Radke, MA,
George F. Smith, MD,
Marsha M. Rohrer, MD, and
Howard J. Burgess II, MD
Family Practice Program
Edward W. Sparrow Hospital
Lansing, Michigan

References

1. Radke KF, Crow HE, Carley WC: The nonrotational model. Fam Pract Recert 4(6):31, 1982
2. Crow HE, Rohrer MM, Carley WC, et al: Non-rotational teaching of obstetrics in a family practice residency. J Fam Pract 10:831, 1980

Symptom Diagnosis of Candida Vaginitis

To the Editor:

I read with interest the article by Bergman and Berg *(Bergman JJ, Berg AO: How useful are symptoms in the diagnosis of Candida vaginitis? J Fam Pract 16:509, 1983)* assessing the usefulness of symptoms in diagnosing Candida vaginitis. I agree wholeheartedly with their conclusions and would like to add an analysis of symptoms of the patients who appear in our study of colonization of C albicans in vagina, rectum, and mouth *(Bertholf ME, Stafford MJ: Colonization of Candida albicans in vagina, rectum, and mouth. J Fam Pract 16:919, 1983).*

Of 341 patients receiving pelvic examinations for any reason, 78 (23

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Patients want to hear from their primary care physicians more often — according to the results of a recent survey

We asked patients how they felt about receiving a newsletter from their physicians which contained brief articles about some of the more recent discoveries and advancements in the field of medicine, explained how best to use the services of their family doctor, and offered practical tips to improve their own and their family's health.

90% of those surveyed were ready to receive a regular newsletter from their physicians. In fact, almost 80% not only were ready but expressed great enthusiasm with such comments as these...

- I would be favorably impressed and would feel he was thinking about me.
- It would be like the old days when doctors really cared.
- Good — it would be the voice of authority.
- I'd be very pleased. I'd have much more respect.
- I would have respect for him if he took the time to do that.

Respect was an important issue with more than half of the respondents who stated they would have more respect for their physician if he took the time to send them a newsletter on a regular basis.

For complete survey results and information on a special newsletter, "For Your Health," specifically designed for primary care physicians to send to their patients on a regular basis complete coupon at right.

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percent) grew C albicans when vaginal contents were cultured on modified Nickerson medium (Microstix-Candida, Ames Laboratories). Only 41 (53 percent) of these 78 patients complained of vaginal pain, burning, itching, discharge, or odor. Ninety-eight other patients had vaginal symptoms but negative vaginal cultures. Since these 139 symptomatic patients represent the possible source of telephone calls asking for relief, an analysis of their symptoms was made attempting to find one or more of these vaginal symptoms that might yield an accurate prediction of positive vaginal culture.

Of 27 patients who complained of vaginal pain alone or in combination with other vaginal symptoms, 8 were vaginal-culture positive and 19 were vaginal-culture negative for C albicans. Of 45 patients who complained of burning alone or in combination, 26 were culture positive and 19 were culture negative. Of 61 patients who complained of vaginal itching alone or in combination, 29 were culture positive and 32 culture negative. Of 78 patients who complained of vaginal discharge, 22 were culture positive and 56 were culture negative. Of 42 patients who complained of vaginal odor, 8 were culture positive and 34 were culture negative. Of 31 patients who complained of concurrent vaginal burning and itching, 19 were culture positive and 12 were culture negative. Of 75 patients who complained of either vaginal burning or itching or both, 36 were culture positive and 39 were culture negative.

Had any of the 139 symptomatic women asked for a telephone diagnosis, only the relatively few who had vaginal burning (26 of the 41 culture-positive women) or had a combination of burning and itching (19 of the 41) would have had better than a 50 percent chance of having a correct diagnosis made. The presence of a discharge was so prevalent in the culture-negative women (56) that it was entirely useless in predicting Candida vaginitis. A little less than one half of the women who had vaginal itching had positive cultures.

The physician who offers a telephone opinion concerning vaginal symptoms and the patient who accepts it should each understand that it is nothing more than guesswork.

Max E. Bertholf, MD
Daleville, Virginia

Alcohol Studies Program

To the Editor:

I am responding to Dr. Frederick A. Montgomery's recent letter to the editor in the February 1983 *Journal of Family Practice (Alcohol education for family practice residents, letter. J Fam Pract 16: 223, 1983)*. We have instituted a similar, but more abbreviated, alcohol studies program for our fourth-year medical students during their required rotation on family and community medicine. The rotations are for eight weeks only and include placements in various family health clinics, didactic seminars, and community medicine projects. We recently introduced the alcohol studies program, which consists of two visits to alcohol treatment programs, attendance at an Alcoholics Anonymous (AA) meeting, and seminars on alcoholism (one facilitated by AA physicians). The seminars also include videotapes and discussion dealing with physician attitudes about alcoholism and physician impairment.

We are currently developing a formal evaluation tool for this program. However, student feedback has been extremely positive this year. The usual reaction is that this is an important issue that needs to be addressed much earlier and more comprehensively in their medical education. The students are usually very appreciative that we have presented these issues, but almost feel "teased" because we are able to barely scratch the surface of this important issue because of time limitations.

William B. Shore, MD
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Division of Family and Community Medicine
University of California, San Francisco
San Francisco, California

Acute Pulmonary Edema Precipitated by NSAIDs

To the Editor:

The sodium-retaining properties of the nonsteroidal anti-inflammatory drugs (NSAIDs) are well known.[1,2] Nonetheless, in a noncardiac population this side effect is frequently forgotten, since it is not clinically relevant. Healthy patients do not usually manifest any signs or symptoms of fluid retention. Three cases were recently seen that illustrate the previously unreported phenomenon of acute pulmonary edema secondary to the recent addition of an NSAID to a patient's drug regimen. Now that these drugs are so widely used for rheumatoid arthritis and osteoarthritis, gout, pseudogout, pain, etc, the physician needs to be aware of this sodium and fluid retention possibility.

A 75-year-old woman being

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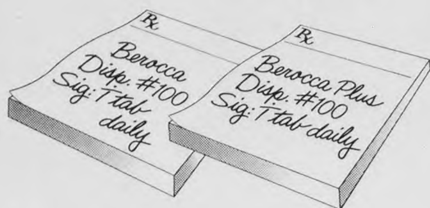

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treated with quinidine, furosemide (Lasix), potassium gluconate (Kaon), and nitroglycerin as needed was started on phenylbutazone (Butazolidin) for osteoarthritis. Five days later she awoke in the night to find herself extremely short of breath, nauseous, diaphoretic, and experiencing substernal chest pain. The county emergency medical service was called, found the patient in marked respiratory distress, and transported her to the hospital.

On admission the patient was in marked respiratory distress. Her vital signs were as follows: blood pressure 200/90 mmHg, pulse 120/min, respirations 30/min, and temperature 97°F. She was markedly diaphoretic. Her heart sounds were distant. Her lungs revealed rales throughout both lung fields bilaterally. She had edema (1-2+) in both legs.

The patient had a past medical history of mitral stenosis, osteoarthritis, and congestive heart failure previously well controlled. She had no history of chronic obstructive lung disease and no previous episodes of acute severe dyspnea.

The patient was treated with furosemide, morphine sulfate, and aminophyllin, and within 1½ hours diuresed 1,700 mL of fluid and was essentially asymptomatic.

In the year previous to this patient's episode, two other elderly patients were seen who exhibited a similar course within 7 to 10 days of beginning NSAIDs (one on Naprosyn, one on Motrin).

The literature discusses three mechanisms that could explain this phenomenon. As stated above, all of the NSAIDs possess the property of sodium retention, probably on a prostaglandin-mediated basis, and can thus cause fluid retention.[1-3] There are case reports and studies in the British literature that postulate a direct antagonism of the diuretic effects of furosemide mediated via prostaglandins at the renal tubular level.[4-6] In addition, toxic levels of salicylates have been shown to cause pulmonary capillary leak and a noncardiogenic pulmonary edema without heart failure.[7,8]

This information indicates that compensated failure is a relative contraindication to the use of NSAIDs. However, when they must be used, the patient should strictly avoid dietary sodium excess and should probably be instructed to weigh daily, at least initially, and report any weight gain. Perhaps occasionally an increase in or an additional diuretic would be added or the patient placed on digitalis.

Alan Jon Smally, MD
St. Petersburg, Florida

References

1. Toxicity of nonsteroidal anti-inflammatory drugs. Med Lett 25:15, 1983
2. Goodman LS, Gicman A (eds): The Pharmacologic Basis of Therapeutics, ed 6. New York, Macmillan, 1980, pp 691, 699, 711
3. Raynor DH: NSAIDs and furosemide induced diuresis, letter. Br Med J 282:988, 1981
4. Laiwah ACY, Mactier RA: Antagonistic effect of NSAID's on furosemide induced diuresis in cardiac failure. Br Med J 283:714, 1981
5. Symmons D, Kendall MS: NSAID's and furosemide induced diuresis, letter. Br Med J 283:988, 1981
6. Faunch R: NSAID's and furosemide induced diuresis, letter. Br Med J 283:989, 1981
7. Heffner JE, Sahn SA: Salicylate induced pulmonary edema. Ann Intern Med 95:405, 1981
8. Heffner JE, Starkeyt AP: Salicylate induced non-cardiogenic pulmonary edema. West J Med 130:263, 1979