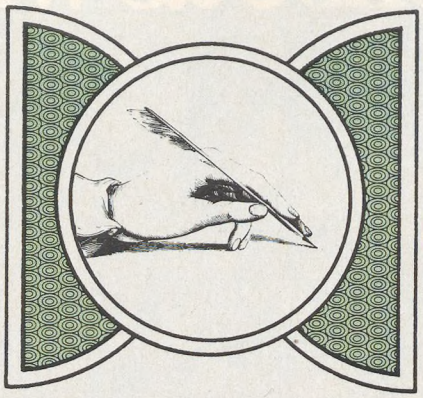
Letters to the Editor



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.

Outpatient Failed Appointments

To the Editor:

A challenge for many family practice clinics is to provide patients efficient access to their physician. However, high no-show rates prevent timely access to care by displacing available appointment times into the future. The result is long waiting times for appointments. Furthermore, acute problems are deferred or managed inappropriately (ie, by emergency room visits) if a schedule appears completely "booked" when in fact there is available space once no-shows are taken into account.

I commend Drs. Barry and Daniels (Barry SP, Daniels AA: *Effecting Change in Outpatient Failed Appointments. J Fam Pract 1984; 18:739-742*) for their efforts in trying to demonstrate whether an introductory video tape can reduce the number of failed appointments. Their preliminary findings of success using video taping are encouraging, but many factors that could confound their results were not addressed. For example, since physician continuity affects no-show rates, the authors did not state whether the randomization process resulted in an equal spread of educational interventions among first-, second-, and third-year residents. This is important, since third-year residents have more clinics available for patient care. One could speculate that these residents might follow their patients more frequently and thereby establish greater physician continuity than would first- or second-year residents. In fact we are left with no sense of the effectiveness of the randomization process.

Another factor which could confound the results of this study is the effect that frequency of cancellation of clinics by residents has on failed appointments. Our experience has shown that patients *expect* to have their appointments rescheduled because of so frequent cancellation of clinics by residents. The impact of cancellation and re-

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scheduling of clinics on no-show rates has received no mention in the literature. Residents having a greater rescheduling rate might anticipate a greater no-show rate. Possibly future studies will reveal the importance of this factor on no-show rates in family practice centers.

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Throat Cultures

To the Editor:

I believe that the conclusions reached by J.C. Shank and T.A. Powell in their article "A Five-Year Experience with Throat Cultures" *(J Fam Pract 1984; 18:857-863)* are not justified by their data.

They found that cultures were positive for streptococci in 18 percent of children aged 6 to 15 years who were clinically diagnosed as being viral. From this they conclude that clinical diagnosis is inaccurate despite the fact that they quote a carrier rate of 15 to 20 percent in prior studies. In the absence of titers, one can not conclude that a clinical diagnosis of viral was inaccurate given the high carrier rate. The clinician may elect to treat these children as having an active infection, but he can not conclude that the positive culture represents a true infection.

They also concluded that there was no evidence that physicians could be taught to increase their diagnostic accuracy. In their study, 4 faculty members did 413 cultures over a five-year period—an average of 20 cultures per year per physician. It would be difficult to improve clinical acumen when a procedure is done so infrequently. Moreover, the guidelines they used in making a clinical diagnosis of streptococcal pharyngitis are known to be imprecise. Their decision to not include an equivocal category prevented participants from limiting their diagnosis of streptococcal pharyngitis to cases that had a high probability of being streptococcal.

Finally, they do not comment on the significance of the 9 percent false-negative rate found in control cultures. The existence of false negatives means that cases clinically diagnosed as being streptococcal but considered to be viral on the basis of a negative culture may have indeed been streptococcal.

When carrier rates, false negatives, and the effect of an equivocal category are considered, the case for clinical diagnosis is much better than the authors have concluded.[1]

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Reference

1. Forsyth RA: Selective utilization of clinical diagnosis in treatment of pharyngitis. J Fam Pract 1975; 2:173-177

Diagnosis of Candida Vaginitis

To the Editor:

There are several problems with the recent article by Bergman, et. al. *(Bergman JJ, Berg AO, Schneeweis R, Heidrich FE: Clini-*

cal comparison of microscopic and culture techniques in the diagnosis of Candida vaginitis. Journal of Family Practice 1984; 18:549-552). These problems limit the usefulness of their recommendations for the laboratory evaluation of women with symptoms of vaginitis.

The first problem is that the study population included patients with a variety of reasons for a pelvic examination. While a majority of these patients (65 percent) complained of "vaginal symptoms," what percentage presented to the office specifically for evaluation of these complaints? This consideration is especially important for studies of Candida vaginitis because whether the presence of the organism is synonymous with the "disease" is unclear. Is C albicans always a pathogen and does it therefore always require treatment? It is also unclear how clinicians should best respond to the asymptomatic patient who is incidentally found to have genitourinary candida. By mixing the patient populations, the authors have made it impossible to use their sensitivity and specificity values in determining the test predictive values for the everyday clinical situation of the symptomatic patient.

The second major problem with this study is the shockingly low rate of positive KOH slides. We believe that a major reason for this could be the specimen collection technique that was used. In the study, a single swab was used to collect the specimen from the lateral vaginal wall. This single swab was then used for four different tests. One fourth of the swab surface was used for each test. This obviously limits the quantity of material available for the microscopic study and is equivalent to taking a single loop full of urine and plating three cultures and then using the remaining urine on the loop for the microscopic examination of the specimen. We recommend using two, 6-inch cotton swabs and obtaining a large quantity of vaginal secretions from wherever they pool in the vagina.[1] This is usually in the vaginal vault, beneath the cervix. The specimen is then suspended into a small quantity of normal saline in a centrifuge tube and taken to the laboratory for examination. It is our belief that this technique enhances the sensitivity of a wet mount preparation.

Finally, the authors suggest that the poor results of their KOH testing could be due to either inadequate time taken in examining the specimen or inadequate test training. It is our experience that clinicians are frequently not trained and are excessively casual in performing this test. Failure to perform a test properly is an avoidable cause for a low test sensitivity.

The KOH examination can be a rapid and inexpensive test with a high specificity. Further research will be needed to identify the test sensitivity and to clarify the pathogenicity of the candida organism.

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Reference

1. Fischer PM, Addison LA, Curtis P, Mitchell JM: The Office Laboratory. Appleton-Century-Crofts, East Norwalk, Conn, 1983

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