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.

BLACKMARKET STEROIDS COMPLICATE ACNE THERAPY

To the Editor:

This letter was prompted by a telephone call to the Drug Information Service at the University of Utah Health Sciences Center from a concerned parent seeking identification and information regarding a bottle of pills she had found in her teenage son's room. The handwritten label on the bottle indicated it contained methandrostenalone. The woman wanted to verify that this was the same medication prescribed for her son's acne.

She was informed that the medication in question was a well-known anabolic steroid used by many athletes to increase muscle mass, and that the drug carries the risk of many adverse effects, including acne. Nevertheless, she was relieved that her son was not on "hard drugs." She was also advised to discuss the use of this illicit medication with her son as well as the physician treating his acne.

It has been documented that at least 1 million athletes are using anabolic steroids,[1] most of which are easily obtained through blackmarket sources.[2] Very little, if any, drug education is connected with anabolic steroids obtained in this fashion. This lack of education is in part responsible for most illicit users exceeding the recommended therapeutic dosages by several times.[2] Certainly, education regarding their efficacy and side effects is a key in reducing their use in healthy individuals.

Young athletes may seek medical treatment for acne induced by anabolic steroids. Physicians unaware of anabolic steroid abuse may embark on a therapeutic regimen that includes systemic medications such as tetracycline and isotretinoin (Accutane). Both of these medications can cause hepatotoxicity, as can anabolic steroids.[3] The concomitant use of any of these medications may increase the risk of hepatic injury. While isotretinoin decreases sebaceous gland activity, the anabolic steroid stimulates this activity, thus confusing the clinical picture of the acne patient.

In conclusion, we believe that physicians should routinely query young athletes concerning anabolic steroid abuse prior to initiating acne therapy, especially systemic therapy. If abuse is discovered, discontinuing the anabolic steroid is the first step in the treatment of the athlete's acne and an important step in reducing the individual's risk of liver dysfunction,[3] liver cancer,[3] coronary artery disease,[4] testicular dysfunction,[3] gynecomastia,[3] and abnormalities of skeletal muscle tissue.[5]

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ECG IN AMBULATORY CARE

To the Editor:

I agree with the article by Robert Nissan and Maria Encarnacion, "Clinical Value of the Electrocardiogram in Ambulatory Care" (*J Fam Pract 1987; 24:361–363*), that routine periodic screening of all adults with electrocardiogram (ECG) is unjustified. I believe the case for selective

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screening, though, is far more complex than presented.

First, while only two of the authors' cases required immediate treatment, many of the other diagnoses listed suggested the need for further workup and treatment. More follow-up on the other abnormal cases would be required to define truly whether 0.5 percent, 30.3 percent, or something in between represents the "true positive" rate for ECGs. For a test that is totally benign and fairly inexpensive, even low positive rates should be acceptable. A cost-benefit analysis would be interesting; I suspect ECG would compare favorably with other screening procedures such as sigmoidoscopy.

Second, the authors question the usefulness of the baseline ECG based on a single study[1] that examined its usefulness in deciding whether to admit a patient with chest pain. Clearly in the emergency room the past ECG is of minimal help; it can be much more useful in the hospitalized patient with atypical pain and nonspecific ECG changes. In this context it helps gauge the physician's index of suspicion and may alter the course of further, more invasive testing.

Third, in hypertension the presence of left ventricular hypertrophy (LVH) can suggest not only the duration of disease, but also the adequacy of control, ie, the average daily blood pressure.[2] Following potentially reversible changes of hypertension such as LVH[3] may be a better indicator of treatment efficacy than a single office blood pressure reading. In this setting the ECG may actually be underutilized.

Finally, the authors cite the anxiety induced by performing an ECG on a patient. My experience more often is the opposite: the patient is relieved when told that his ECG is fine. Abnormal ECGs in themselves do not provoke anxiety; rather, the physician who presents the interpretation can provoke undue anxiety, appropriate concern, or reassurance. We need to realize the limitations of the tests, rather than just stop ordering them.

I believe the authors' data represent a liberal but appropriate use of the ECG. While not a screening test for the general population, selective screening of high-risk groups and liberal use in symptomatic patients are certainly justified in a society increasingly geared toward the prevention and early detection of disease.

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HYPONATREMIA RESULTING FROM PELVIC ULTRASOUND PREPARATION

To the Editor:

Even noninvasive testing may be associated with unappreciated hazards. The following case illustrates the infrequently reported,[1] and often overlooked, problem of hyponatremia resulting from free water intoxication associated with pelvic ultrasound preparations.

A 64-year-old woman was admitted to the hospital for severe lower back pain, of one week's duration, radiating to the left buttock. The patient had well-compensated thyroid disease, but no history of diuretic usage, renal disease, adrenal disease, liver disease, or congestive heart failure. Vital signs were as follows: temperature 37 °C, pulse 96 beats per minute, blood pressure 150/80 mmHg, and respirations 18/min. Physical examination was remarkable for tenderness over the left sciatic notch and a grade 2/6 systolic heart murmur localized to the aortic region. There were no signs of dehydration or edma. Admission laboratory studies disclosed the following values: serum sodium 138 mmol/L (138 mEq/L); potassium 4.3 mmol/L (4.3 mEq/L); and chloride 108 mmol/L

(108 mEq/L). Results of other tests, including bicarbonate, blood urea nitrogen, creatinine, glucose, urinalysis, complete blood count, thyroid function, and a chemistry panel, were all within normal limits.

Medications on admission were carisoprodol-aspirin (Soma Compound), ibuprofen (Motrin), oxycodone-acetaminophen (Tylox), and L-thyroxine (Synthroid). The patient received one injection of dexamethasone (Decadron) the day of admission. On the second day of hospitalization, pelvic ultrasonagraphy was ordered. In preparation for the echogram, the patient drank 1,350 mL of water over one to two hours. Upon returning from the examination, the patient complained of severe weakness. Two hours later, a nurse found the patient disoriented and aphasic. Laboratory test results included serum sodium 123 mmol/L (123 mEQ/L), 93 mmol/L chloride (93 mEq/l), and potassium 3.5 mmol/L (3.5 mEq/L). Serum osmolarity was 249 mmol/L (249 mOsm/L). Calcium, glucose, magnesium, and complete blood count were normal. The patient was given an intravenous solution of 3 percent saline, followed by 5 percent glucose in normal saline. Six hours later the sodium was 129 mmol/L (129 mEq/L). Within 14 hours the patient's serum osmolarity, electrolytes, and mental status were back to normal.

Subsequent workup was pertinent for L-4 and L-5 disc disease. There were no further electrolyte abnormalities or neurological deficits noted during hospitalization or subsequently as an outpatient.

Although pelvic ultrasound is commonly considered a "benign examination," this woman's course is an example of how an ultrasound preparation can result in symptomatic hyponatremia. Even though a normal individual may drink up to 15 liters of water without a change in serum sodium levels,[2] far less water may dilute the serum sodium in elderly individuals and patients whose ability to excrete free water is impaired. In this case, a documented oral intake of 1,350 mL resulted in hyponatremia. Clinicians should be aware of this potential side effect if a patient develops confusion after an ultrasound examination.

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PATIENT SATISFACTION

To the Editor:

The article in your April issue by Paula Cowan, "Patient Satisfaction With an Office Visit for the Common Cold" (*J Fam Pract 1987; 24:412–413*), raises a poignant question for all of us in primary care.

The crux of the issue, I feel, is the successful interaction of the expectations, needs, and communication skills of both the patient and the physician,[1] and not just the receipt of a prescription.

I believe in my practice a large number of people expect some written prescription for their expense. I find it surprising that 36 percent were satisfied with reassurance only. Were the patients fee-for service, capitation, or gratis? Cowan's article alludes to the pressure we all feel to give the patient something. Unfortunately, in my experience, many patients see the drugs received as a rite of passage into the world of recognition or confirmation of their illness. They also may be expected to receive medication by loved ones, employers, and other interested peers.

Many people today are under enormous external and internal pressure not to be sick and to get better at whatever the cost. Of course, the physician is always placed in the role of determining what is at stake, in terms of behavioral issues.

What I feel health care providers are faced with today is patient reeducation on a grand scale. These captains may find themselves sailing against the tide of old drug-prescribing habits.

Cowan's research can serve to promote discussion about the difficult process of simultaneously giving the patient something appropriate, effective, and satisfying. In our system most people feel satisfied if they get something.

She unfortunately did not examine the impact of all the items received during the office transaction. It is important to point out that the physician himself or herself is a drug. We are always giving something; we are giving ourselves.

Eric J. Cassell[2] also shows the power of information as a therapeutic tool. The something we are giving (implied agreement) may be educational, eg, what to look for if the viral infection becomes bacterial; our agreeing to be available for any new problems provides engagement, and our input, counseling, points out and helps patients with the conflict of getting better at any cost. The visit itself may satisfy the patient by providing an avenue for disclosure and insight, thereby avoiding taking an unnecessary medication (about which both physician and patient may feel good).

There is so much happening at the time of visit in both the open and hidden agenda. Cannot today's visit for the common cold set the stage for tomorrow's consultation on hypertension or marital discord, for example?

Recently the question of patient satisfaction and behavioral science education was raised.[3] The authors concluded, "The findings that significant differences in patient satisfaction exist on the 'art of care' scale and in the predicted direction certainly points to the importance of the behavioral sciences for patient care and overall residency education."

Although Dr. Cowan's sample is small, her article contributes to that fund of information in family practice skills that sets us apart from the mainstream of medicine. Would the same conclusions hold true for all systems of health care delivery including health maintenance organizations? I hope we will see more research in this direction.

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