

## *C trachomatis* SCREENING

To the Editor:

I commend Cullen et al on their article, which contributes valuable epidemiologic data about *Chlamydia trachomatis* prevalence in a specific population group.<sup>1</sup> The investigation demonstrates several important points. First, family physicians play an essential role in the diagnosis and management of sexually transmitted diseases. The result of this involvement is a reduction or prevention of the complications of *C trachomatis* infection.

The determination of disease prevalence enables practitioners to develop screening guidelines as to whom and when to screen. Furthermore, appropriate selection of screening test methodology is dependent on disease prevalence. Prevalence data also assist administrators to "triage" limited health care budget funds to maximize a yield of overall health in the community. The strain of acquired immunodeficiency syndrome on funds allocated for research on sexually transmitted diseases makes similar studies beneficial and necessary.

The authors implied that there is a current absence of *C trachomatis* screening criteria. Handsfield et al<sup>2</sup> identified selective screening criteria for *C trachomatis* in a primarily non-gravid population (13% gravid). The five independent risk factors were age 24 years or younger, a new sexual partner within the previous 2 months, cervical friability, endocervical mucopus, and no contraception or nonbarrier contraception. Further screening criteria specifically for pregnant patients would be helpful.

Ideally, pregnant women should be screened for *C trachomatis* during the first trimester to reduce the chance of preterm labor and premature rupture of membranes. A screen during the third trimester would reduce the incidence of *C trachomatis* conjunctivitis and pneumonia. To avoid mandating compliance, the

Centers for Disease Control has suggested that pregnant women should be screened for *C trachomatis*, syphilis, and *Neisseria gonorrhoeae* "if possible, at their first prenatal visit, and, for women at high risk, during the third trimester."<sup>3</sup> The Native American women in this investigation deserve both screens for *C trachomatis* during pregnancy.

The findings presented by the authors are an example of clinical research that educates physicians, and more importantly, makes us aware of *C trachomatis*. The awareness will result in a greater diagnosis of infection and an improvement of health care for our patients.

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2. Handsfield HH, Jasman LL, Roberts PL, et al. Criteria for selective screening for *Chlamydia trachomatis* infection in women attending family planning clinics. *JAMA* 1986; 255:1730-4.
3. Centers for Disease Control: 1989 Sexually transmitted diseases treatment guidelines. *MMWR* 1989; 38(S8):28.

## ADMISSION BY FAMILY PHYSICIANS vs INTERNISTS

To the Editor:

I enjoyed the paper by McGann and Bowman that compared the morbidity and mortality rates for family physicians' and internists' admissions.<sup>1</sup> Although the majority of primary health care in our country is provided by family physicians and general internists, there is no clear consensus on which group provides the most cost-effective services.

The literature regarding cost-effectiveness comparisons between family physicians and internists is scarce and does not include data that allow one to make clear judgments. Studies generally show that family physicians use fewer resources in delivering health care to their patients than internists use.<sup>2-6</sup> Furthermore, patient satisfaction does not appear to differ between the two types of providers.<sup>7,8</sup> But there has been little research comparing health outcomes between these different resource users. Although McGann's recent study has some limitations, it does provide additional support to the idea that family physicians provide care that yields comparable outcomes to care provided by internists.

The increasing concern about controlling the costs of health care will likely force payers to search out the most cost-effective providers. Additional outcome studies are required to prove that the more costly practice styles of some physicians do not necessarily yield commensurate benefits to justify them. At that point it will be evident that care provided by family physicians is equally effective and is the best value for our society.

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### References

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2. Bertakis K, Robbins J. Utilization of hospital services—a comparison of internal medicine and family practice. *J Fam Pract* 1989; 28:91-6.
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6. Robbins J, Bertakis K, Rose S. Costs of care provided by trainees in internal medicine and family practice. *West J Med* 1983; 138:118-9.
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*The preceding letter was referred to Drs McGann and Bowman, who respond as follows:*

We have received and reviewed the letter by Timothy J. Moore, MD, MS, concerning our article, and we thank him for his remarks. As noted by Dr Moore, there is little in the literature that adequately addresses differences in the quality and cost of care provided by family physicians and internists. In fact, this lack was the impetus for our research. Since quality and cost are so important, and the training of these two specialties is different, we feel that continued study in this area is important. If further studies confirm that the quality of care is the same but more costly when delivered by internists, changes in the training offered by internal medicine residences would be indicated.

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## **STREPTOCOCCAL TOXIC SHOCK**

To the Editor:

The clinical course reported in the case report on group A  $\beta$ -hemolytic streptococcal toxic shock<sup>1</sup> is not typical of streptococcal toxic shock as reported in the literature. The first

report of streptococcal toxic shock by Cone et al<sup>2</sup> described two critically ill patients, both of whom required intubation and one of whom required pressor support. Batter et al<sup>3</sup> then described three cases, in which two patients required intubation, two exhibited a desquamating rash, and all developed renal failure. Stevens et al then presented a series of 20 patients of whom 80% had renal impairment, 55% had adult respiratory distress syndrome, and 20% had a desquamating rash. Most required pressor support, and 30% died. The most prevalent strains were M-3-T-3 and M-1-T-1.

The case of GABHS sepsis presented in *The Journal of Family Practice* does not exhibit the severity of illness and the multiple organ failure that are characteristic of streptococcal toxic shock syndrome.

*Neal F. Devitt, MD  
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### References

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*The preceding letter was referred to Dr Herold, who responds as follows:*

In reply to Dr Devitt's letter concerning my recent brief report (Herold AH. *Group A  $\beta$ -hemolytic streptococcal toxic shock from a mild pharyngitis*. *J Fam Pract* 1990; 31: 549-51), the patient was severely ill. The patient spent the first 4 days of a 2-week hospitalization at a tertiary care hospital in the intensive care unit. Vigorous fluid resuscitation and antibiotics restored her blood pressure

to normal. Fortunately, vasopressor agents were not needed. Also, she did have multiple organ system involvement. As mentioned in the paper, she had a pleural effusion, hepatopathy, azotemia, and proteinuria. During hospitalization, she developed creatinemia, further suggesting renal impairment, and glucose intolerance. All abnormalities reverted to normal within 1 month.

The patient's symptoms, which included hypotension and orthostasis, the involvement of multiple organ systems, and the recovery of group A  $\beta$ -hemolytic streptococcus (GABHS) from the blood and oral pharynx, meet the criteria for streptococcal toxic shock syndrome. Desquamation of the skin is an infrequent finding. Patients presenting with this syndrome will have a spectrum of severity from mild shock to irreversible vascular collapse and death. What is remarkable about this case is that it occurred in a young, healthy female who survived and has remained in good health. Also remarkable was that virulent strains of GABHS were present in Florida at the time they were being reported in other parts of the nation. Identification of the particular strain of GABHS would have increased the interest of this case report.

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## **OFFICE RADIOGRAPHS**

To the Editor:

The article by Halvorsen and Swanson (Halvorsen JG, Swanson D. *Indications for office radiographs*. *J Fam Pract* 1990; 31:521-9) left out any mention of the legal profession's impact on the decision to order x-ray examinations. The information given in this article was excellent information for when I was in training in the early 1960s, but today it is worthless. It contains beautiful didactic material but tells one nothing about how to handle the decision to order an x-ray



examination in relation to lawyers and juries. Inevitably, the physician is confronted with either "Doctor, you mean you didn't x-ray this child's head?" or "Doctor, why did you subject this poor child to dangerous x-rays?"

Perhaps retaining a lawyer to consult with the physician and the radiologist concerning each case is the answer to this dilemma. But, then we get into the issue of rising health care costs.

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## OUT-OF-HOSPITAL BIRTHS

To the Editor:

Once again I applaud the Journal for their continuing efforts to publish articles demonstrating the safety and effectiveness of offering alternatives in childbirth (*Acheson LS, Harris SE, Zyzanski SJ. Patient selection and outcomes for out-of-hospital births in one family practice. J Fam Pract 1990; 31:128-136*).

I hesitate to be too critical of an important article such as this one, but I question the statement that 46% of primiparas and 16% of multiparas were assessed as having small or "borderline" findings on clinical pelvimetry. (I assume the 16% of multiparas thus labeled included all those with prior cesarean sections, as I cannot imagine applying that label to such a high percentage of women who had had one previous vaginal delivery.)

In large reported series of patients, we have seen that the true incidence of cephalopelvic disproportion can be as low as 0.1% to 0.33%<sup>1,2</sup> when labor is managed either by aggressively augmenting uterine activity to make it more efficient, or by aggressively eliminating all factors that would tend to inhibit the efficiency of uterine contractions, removing arbitrary time limits, and patiently observing labor as long as no fetal distress is present.

With true cephalopelvic disproportion being virtually nonexistent

in some series, I suspect that we are vigorously overdiagnosing it in others. I also suspect, but cannot prove, that a woman who is told in the first trimester that her pelvis is borderline or "too small" may spend the next several months convincing herself, or being convinced by friends and relatives, that she will need a cesarean section eventually, thus decreasing her motivation to have a vaginal delivery, raising her anxiety levels over the prospect of a long and difficult labor, increasing her catecholamine levels, and ultimately decreasing the efficiency of her contractions and resulting in the fulfillment of a self-fulfilling prophesy.

Knowing what we are capable of achieving, I suggest we stop telling women their pelvises are too small unless there is an obvious deformity noted on examination. We should have more faith in the capacity of the female pelvis for expansion at term and direct our efforts to improving the efficiency of uterine contractions and relaxing the pelvic muscle tension that impedes good labor.

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2. O'Driscoll K, Foley M, MacDonald D. Active management of labor as an alternative to cesarean section for dystocia. *OB/GYN* 1984; 63:485.

*The preceding letter was referred to Dr Acheson, who responds as follows:*

We wholeheartedly agree with Dr Meenan about the importance of positive expectations to the outcome of labor. The women in our practice were not told that their pelvises were "too small," but perhaps that some dimension of the birth canal was less than average or that an unusually large baby might have trouble fitting through. Almost all of these women attended Lamaze classes especially focused on out-of-hospital birth.

They and the doctors and nurses attending them expected a natural delivery in a relaxing setting.

Our experience is not comparable to that of O'Driscoll et al<sup>1</sup> because early augmentation of labor was not an option outside the hospital, and because, in general, our obstetric consultants of that era did not tolerate prolonged second stage or lack of progress in labor without operative intervention.

The high prevalence of "borderline" findings on clinical pelvimetry that we reported is partly an artifact of the data coding rule. "Pelvimetry" was coded as "borderline" if *any* single element (diagonal conjugate, sacral curve, sacrosciatic notch, ischial spines, pubic arch, bituberous diameter, or coccyx angle and mobility) had been noted to be less than average or not optimal. The 16% of multiparas with such findings all had vaginal deliveries; those with prior cesarean sections were not candidates for out-of-hospital births. Pelvimetry "measurements" are fairly subjective. The bias in our situation may have been toward classifying more pelvises as abnormal in an attempt to avoid problematic labors in home or clinic. Since this was a retrospective study, we have no data on test-retest or interrater reliability of clinical pelvimetry as we practiced it. Although suboptimal clinical pelvimetry findings were associated with transfer for abnormal labor progress, this procedure was not sensitive or specific enough to be of great clinical utility. In the future, if shown to be reliable, clinical pelvimetry might be used to select a group of at-risk women for interventions, such as "active management of labor," or provision of a supportive companion, designed to reduce the rate of operative deliveries.

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### Reference

1. O'Driscoll K, Foley M, MacDonald D. Active management of labor as an alternative to cesarean section for dystocia. *OB/GYN* 1984; 63:485.