Letters to the Editor

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MALARIA DIAGNOSIS

To the Editor:

The diagnosis of malaria can be difficult, but family physicians must consider it in returning travelers. The fact that the traveler took mefloquine during the period of exposure should not exclude the diagnosis. Two cases recently treated in our clinic, which is located in an area without endemic malaria, illustrate this point.

A 28-year-old white woman had visited a malaria-endemic area of Ethiopia. She had taken mefloquine 250 mg each week before, during, and for 2 weeks after departing the area. She was seen 3 weeks after her return complaining of fever, headache, and myalgia. A physical examination was unremarkable other than for a fever of 38.3°C (100.9°F). A malaria smear was positive for *Plasmodium vivax* ring forms and schizonts, with 0.1% parasitemia. A urinalysis revealed pyuria, and a urine culture grew >100,000 *Escherichia coli*. The urinary tract infection was treated with ciprofloxacin 250 mg twice daily.

In another case, a 30-year-old white woman also had taken mefloquine while visiting an area endemic for malaria. She presented to our clinic 2 weeks later, still taking mefloquine, complaining of headache, abdominal discomfort, and diarrhea. She had not noted any fever but felt fatigued. The symptoms reminded her of prior episodes of amebiasis, which is common among foreigners in Ethiopia. On examination, she appeared moderately ill. Her temperature was 37.2°C (99.0°F), and a general examination was remarkable for mild abdominal tenderness with hyperactive bowel sounds. Examination of fresh stools failed to reveal ova or parasites, and a stool culture grew only normal intestinal flora. A malaria smear revealed rare *Plasmodium falciparum* ring forms.

In both cases, the patients were treated with three doses of oral halofantrine (500 mg). Halofantrine is a new drug not yet available in the United States. Constitutional symptoms swiftly subsided in both patients; follow-up smears have been negative.

These cases illustrate the need to exclude malaria in ill travelers, regardless of coexistent illnesses and the use of mefloquine, which is the most effective available antimalarial for Africa. A correct diagnosis may require a careful review of thick and thin smears by experienced personnel; both of our patients had very low levels of parasitemia. Family physicians see patients from all over the world and may expect diseases from all over the world as well. We should retain a high index of suspicion for malaria in our patients who are international travelers.

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CERVICOGRAPHY

To the Editor:

As family physicians who practice and teach colposcopy, we wish to comment on Ferris's statement that colposcopy is "expensive, emotionally traumatic, and unnecessary for the 75% to 85% of patients with normal findings."[1] Compared with colposcopy, cervicography would appear to place an additional barrier between the family physician and the primary data. Cervicography requires additional equipment and de facto imposes mandatory consultation on the family physician. Family physicians with a colposcope should be trained to develop their skills so that they can make an accurate diagnosis in the substantial percentage of patients who have questionable Papanicolaou (Pap) smears or questionable visual findings on pelvic examination. Cervicography unnecessarily interimposes a consultation barrier while lengthening the interval of time required for the patient to receive a decision. Therefore, our training goal is to continue the improvement of family physicians' ability to provide immediate and accurate diagnostic information to women regarding their risk of cervical cancer. Done correctly, this should decrease the emotional trauma which is inflicted by unnecessarily waiting for an answer.

Cervicography also creates added cost as a screening tool. Some family physicians have actually reported using colposcopy without placing an additional cost on the patient.[2–5]

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3. Felmar E, Payton CE, Gobbo R, Herbst M. Colposcopy: a necessary adjunct to Pap smears. Fam Pract Recert 1988; 10(11): 21–32.
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The preceding letter was referred to Dr Ferris, who responds as follows:

The purpose of our study was to assess the use of cervicography as an intermediate triage test for the evaluation of atypical cervical cytology reports. In simplistic terms, does it work? Could cervicography eliminate the need for a more lengthy and costly procedure for the majority of patients?

Many clinicians consider colposcopy an aggressive clinical approach for patients with only cytologic atypia. Cervicography may be a more moderate approach positioned somewhere between colposcopy and the least aggressive approach of repeating the Pap smear.

Obvious confusion exists about cervicography. Cervicography equates better with a type of laboratory "test" (ie, Pap smear) than with the clinical "procedure" of colposcopy. Cervicography merely captures a photographic image of the cervix. The "consultation" or test interpretation is not any more a hindrance than

Pap smear or mammogram reports. The cervigram (test result) does not replace the "procedure" of colposcopy. Therefore, cervicography should not be perceived as an impediment or a threat to clinicians who practice colposcopy.

Cervicography should be viewed as an alternative clinical tool that has unique advantages and disadvantages. Cervicography, along with repeat Pap smear, human papillomavirus nucleic acid testing, and colposcopy, has been recognized as a potential triage option for the management of cervical atypia (ASCUS). Cervicography is available to family physicians, the majority of whom do not perform colposcopy, to improve patient care, not to erect barriers.

It is difficult for me to believe that colposcopy, which costs 4 to 5 times as much as cervicography and 5 to 10 times as much as a repeat Pap smear (used to detect the 5% to 25% of patients with premalignant disease, the majority representing low-grade squamous intraepithelial lesions likely to regress spontaneously) should seriously be considered as cost-effective.

New tests should be vigorously challenged regarding their relevance and practicality for medicine. I, too, was initially skeptical, but after analyzing our data, the answer to our first question was clear. Cervicography can work as an intermediate triage test in women with atypia.

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PAIN MEDICATION

To the Editor:

Turner and Denny[1] present an interesting review of the use of antidepressant medications for chronic low back pain. However, several of their statements warrant comment.

The authors state that antidepressant medications can be expensive. As they note, this is true of the newest ones, most notably the selective serotonin uptake inhibitors, including fluoxetine, sertraline, and paroxetine. However, with the exception of nortriptyline, it is not true of the tricyclic antidepressants, the class for which there is the most support for use in pain syndromes.[2] Furthermore, because these medications appear to provide analgesia to many patients at a dose lower than that required for them to exert an antidepressant effect, many of the side effects listed by the authors are less problematic than when the medications are used for depression.

Your readers who consider using the antidepressants for pain should also be aware of another more comprehensive review of the literature on this subject that Turner and Denny failed to cite. In that review, Magni[3] also found that there are limited data supporting the benefits of antidepressants for low back pain but noted that there is evidence of their efficacy for a variety of other pain disorders, including migraine headaches, neurogenic pain, fibrositis, and probably osteoarthritis and rheumatoid arthritis. As these disorders are commonly encountered in primary care settings, it is important that family practitioners recognize the analgesia that antidepressants can provide to their patients.

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2. Choice of an antidepressant. Med Lett 1993; 35:25–6.
3. Magni G. The use of antidepressants in the treatment of chronic pain. Drugs 1991; 42:730–48.

The preceding letter was referred to Drs Turner and Denny, who respond as follows:

We agree with Drs King and Sengstaken that the tricyclic antidepressants generally are much less expensive than the newest antidepressants. However, it is our clinical experience at the University of Washington Pain Center in Seattle that the new, expensive antidepressant medications are increasingly used with chronic pain patients before they are referred to us.

Drs King and Sengstaken write, ". . . because these medications appear to provide analgesia to many patients at a dose lower than that required for them to exert an antidepressant effect, many of the side effects . . . are less problematic than when the medications are used for depression." However, the literature does not demonstrate the superiority of antidepressant medication over placebo in decreasing low back pain, at either low or antidepressant doses. Thus, even when antidepressants are administered in low doses to nondepressed low back pain patients, patients may be bothered by side effects and at the same time receive no pain-relieving benefit. It is our experience that many chronic pain patients are bothered by side effects even with low doses.

Although we did not analyze the evidence for the efficacy of antidepressants for any pain syndrome other than low back pain, we read a number of general reviews, including Magni's article,[1] when we conducted our literature synthesis. Magni and others have concluded that antidepressants are efficacious for a number of pain disorders. Onghena and Van Houdenhove[2] conducted a meta-analysis on 39 controlled studies on the analgesic effects of antidepressants for various pain conditions. They commented on the methodological problems characterizing the literature, as did a subsequent letter to the editor[3] concerning this meta-analysis. Yet another systematic review[4] documented the poor quality of most clinical trials in the area and concluded that the efficacy of antidepressants for chronic low back pain remained unproven. This review further concluded that the efficacy of antidepressants for pain syndromes other than headache remains unproven.

We suspect that all who systematically review the literature of clinical trials evaluating the efficacy of any antidepressant medication for any chronic pain problem will agree that the studies have significant methodologic flaws and limitations and that higher quality studies are needed to resolve this issue.

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2. Onghena P, Van Houdenhove B. Antidepressant-induced analgesia in chronic nonmalignant pain: a meta-analysis of 39 placebo-controlled studies. Pain 1992; 49: 221–30.
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