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. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication. Send letters to Paul M. Fischer, Editor, The Journal of Family Practice, 519 Pleasant Home Rd, Suite A-3, Augusta, GA 30907-3500, or Fax (706) 855-1107.

GENERALIST PHYSICIANS REVISITED

To the Editor:

Drs Newton, Goldstein, and Curtis propose that "the best criterion for deciding whether a particular discipline is 'generalist' should be to note the proportion of the population who routinely see a physician from that discipline" (*Newton WP, Goldstein AO, Curtis P. Generalist physicians: a modest proposal [editorial]. J Fam Pract 1994; 39:19–20*). By including the provision that physicians must be seen by patients, this criterion unfairly excludes pathologists and laboratory medicine "specialists," who certainly provide important medical services to women and men of all ages by reading Papanicolaou smears and biopsies and overseeing diagnostic laboratories. Moreover, expanding this criterion by not requiring that the physician see the patient would be more consistent with their inclusion of radiologists as generalists. In this day of well-trained technicians and busy radiology departments, patients often have no more direct contact with their radiologist than with their pathologist.

With the proposed criterion for generalist, the correct ratio of generalists to specialists in the United States is approximately 1:1, the most frequently cited goal for purposes of health care reform. We owe a debt of gratitude to the authors for so swiftly resolving the generalist shortage without the need for difficult and potentially divisive health care reforms.

David Thom, MD
Palo Alto, California

To the Editor:

I support a real primary care test for generalist, such as: what doctor can a family call at 3:00 AM when a mother and her 4-year-old son are vomiting and have a temperature of 102.3°F? They can call us. We are family doctors in the real world of private family practice. The true definition of the generalist primary care physician is represented by the members of the American Academy of Family Practice. The private family practitioner is the only doctor who is fully trained to provide comprehensive primary care to women. Family medicine is the generalist discipline of women's health. I reject the conclusions of the executive director of the American Medical Women's Association (who, by the way, is a psychiatrist) that are quoted in the editorial (*Newton WP, Goldstein AO, Curtis P. Generalist physicians: a modest proposal [editorial]. J Fam Pract 1994; 39:19–20*).

The definition of generalist need not be redefined in an effort to blend primary care with nonprimary care. Its present meaning, as outlined in their first paragraph, should and must be supported by all primary care doctors and held dear to heart as a great truth.

Wm. Jackson Epperson, MD
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The preceding letters were referred to Drs Newton, Goldstein, and Curtis, who respond as follows:

Satire is risky rhetoric, perhaps doubly so in a medical journal in which readers are accustomed to getting "facts." In response to our recent editorial[1] on the definition of generalism, we have received a number of letters from committed family physicians outraged at such a preposterous proposal. The proposal was indeed preposterous, as we took commonly heard arguments to their logical extreme. We apologize to any we may have offended. Other physicians, like Dr Thom, read our intent very well. The point he makes is quite valid: using our "frequency seen" criterion, pathologists are certainly generalists! We would add, in the same spirit as the editorial, why stop at a 1:1 ratio of generalists to specialists? If we work at the definition long enough, we can include 90% to 95% of the population of physicians!

Our editorial was the result of our personal and often surrealistic experiences arising from the "generalist" initiative at our medical school. In our region of the country, our specialist colleagues have recognized the trends in educational and clinical reimbursement and are discovering that they, too, are generalists. In the last 3 months, we have overheard an otolaryngologist discussing primary care of the nose, a nephrologist claiming that primary care is an intuitive part of his domain, a cardiologist proclaiming his responsibility for prevention, except for immunizations, breast and pelvic exams, and an obstetrician ordering a cholesterol level, "because we're primary care doctors now." We believe that the issue of "who is a generalist" is fundamental to health care reform.

We also believe that family physicians must get involved in the debate. We can and should argue empirically, as Rivo[2] has done recently, but since the debate is political rather than scientific, we should also join the fight with passion in op-ed pieces, radio interviews, and other techniques. In this spirit, Dr Epperson's contribution is very appropriate. For most of us, this sense of individual responsibility and accountability for the person or family rather than the disease or time of night should be fundamental to any new health care system.

One final point is that our discipline is often the prisoner of its own rhetoric. For many years, Family Medicine has emphasized the role of the individual patient and individual choice in diagnosis and prevention. Clinically, this is very appropriate and very attractive to patients, but, as our editorial suggested, it functions poorly as the only basis for policy. We must be concerned with the development of effective health care for the population as a whole as well as for individual patients. In this regard, the Institute of Medicine's almost 20-year-old criteria are a good place to start: accessibility, comprehensiveness, coordination of care, continuity of care, and accountability.[3] Family physicians, general internists, and general pediatricians are the only generalists who address such concerns for individual patients and the population as a whole.

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icine: a definition. Washington, DC: National Academy of Sciences, 1977:1–6.

THROAT CULTURE TO RULE OUT GABHS

To the Editor:

Published reviews on managing group A β-hemolytic streptococcal pharyngitis (GABHS) often contend that a negative rapid streptococcal test must be followed by a throat culture to rule out GABHS.[1–3] This recommendation is usually based on concern that the sensitivity of the rapid strep test is reported to be only 50% to 90%.

The more important indicator for family physicians to consider when evaluating the usefulness of the rapid strep test in managing patients with pharyngitis is the test's predictive value. Specifically, when considering the clinical relevance of a negative rapid strep test, one would be interested in the test's *negative* predictive value. Bayes' theorem states that the predictive value of a test depends on the prevalence (or probability) of the disease.

Pharyngitis symptom scores can predict the probability of GABHS based on the following clinical guidelines: tonsillar exudates; swollen, tender anterior cervical nodes; history of fever; and lack of cough.[4] A patient is assigned a score according to the total number of signs and symptoms present, with each worth one point. Wigton et al[5] report a probability of GABHS of at least 42% whenever the pharyngitis symptom score is 2 or more.

The authors may be reporting an inflated probability of GABHS for the following reasons. First, data were collected from adults and not children under 12, who may be more likely to have viral illnesses easily confused with GABHS. Second, patients were recruited only from those seen in an emergency room, presumably selecting subjects with more symptomatic disease and a higher likelihood of GABHS. Finally, this retrospective chart review included only patients with pharyngitis who had a throat culture performed (85%) and did not include those with pharyngitis not undergoing a throat culture.

A similar study was performed by Centor et al,[4] who prospectively evaluated adults with pharyngitis, all of whom received a throat culture. These authors reported a probability of GABHS greater than 20% only when the pharyngitis symptom score was 3 or greater. Thus, if rapid strep tests are performed only when the symptom score is 2 or less (when the pretest probability of GABHS is less than 20%), with a sensitivity of at least 70% and a specificity of 99% (as reported by Centor et al), the negative predictive value of the rapid strep test will be at least 95%.

Achieving a sensitivity for the rapid strep test of at least 70% in the standard office setting has been questioned. In 1992, the Harrisburg Hospital Family Practice Center evaluated the accuracy of performing the rapid strep test in patients with pharyngitis. All 290 patients with a negative rapid strep test had a throat culture performed using standard office procedure. Only 2 of the 290 patients with a negative rapid strep test had a positive throat culture, confirming a negative predictive value greater than 99%. Since the throat culture alone has a sensitivity of 90% and specificity of 99%,[4] it is unlikely that performing throat cultures will further improve the negative predictive value of GABHS testing or completely eliminate the risk of false negatives.

Thompkins et al[6] showed that treating all patients with pharyngitis without testing is the most efficient strategy when the probability of GABHS is greater than 20%. Therefore, it seems prudent to presumptively treat without culturing all patients with pharyngitis symptom scores of 3 or greater, while reserving rapid strep tests only for patients with symptom scores of 2 or less. With this management scheme, throat cultures are unnecessary. For office-based clinicians trying to meet laboratory quality assurance standards, not having to perform throat cultures can relieve a significant burden of time and cost. We encourage further study of this management stratagem in the primary care setting.

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SCREENING QUESTION FOR CAGE

To the Editor:

Diagnosis, treatment, and prevention of alcohol problems have become a great responsibility for all physicians.[1,2] Although there are many tests to identify alcoholic patients, we think they take too long to be done properly in general practice.[3,4] The CAGE test[4] should be used only in the cases of patients who are suspected of drinking in excess, because its four questions may not be adequate for a patient who does not drink at all. Because of this, we think that the patient in question should be asked a preliminary screening question to determine if the CAGE test should be done (ie, "Do you think that your alcohol consumption is . . . ?").

We conducted research to find out the difference between the real consumption of alcohol and what the patient reports in the 24-hour consumption record. We also wanted to know the sensitivity, specificity, and predictive values of the question "How much do you drink?" We took a representative sample of 317 adults who lived in Tarragona, Spain, in 1992. We went to their homes and asked if their alcohol consumption was zero, very low, low, average, high, very high, and requested that they record their alcohol consumption during a 24-hour period. Sensitivity, specificity, and predictive values were estimated. The test was considered positive when the answer was average, high, or very high. The 24-hour consumption record was the reference to consider the screening question as positive; men who drank more than 60 g/day and women more than 40 g/day were considered as positive.

We found an excellent correlation ($P < .001$) in the average alcohol consumption in grams per day (measured by means of the 24-hour record) when they had answered zero (1.6 g/day); very low (20.7 g/day); low (31.2 g/day); average (50.2 g/day); high (67.5 g/day); and very high (133.3 g/day). About 13% of

Table. Sensitivity, Specificity, and Predictive Value of the Question "Do You Find That Your Alcohol Consumption Is [Zero, Very Low, Low, Average, High, or Very High]?" to Detect Excessive Consumption of Alcohol

Response to Screening Question	Presence of Alcohol Problem*	
	Yes	No
Positive (average, high, very high)	28 true positive	42 false positive
Negative (zero, very low, low)	10 false negative	237 true negative

**Based on patient self-report of alcohol consumption recorded during a 24-hour period.*
NOTE: Screening question sensitivity, 73.7%; specificity, 84.9%; positive predictive value, 40%; negative predictive value, 96%.

the men and 5% of the women were considered heavy drinkers.

These results may be considered as acceptable because the preliminary question is able to detect 75% of the participants who meet criteria for excessive consumption. The positive predictive value of the question, which is slightly low (40%), may also be considered as acceptable (Table). We think that the preliminary question may be useful with people who report they do not drink at all and those who report very low or low levels of drinking, because in these cases, health staff can verify these reports (96%) and a CAGE questionnaire would not be needed. The question is also useful for patients who answer "average" because, in these cases, there exists a reasonable suspicion (40%) of excessive consumption, and a CAGE test, which would detect false positives, would be justified.

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ELECTROSURGERY

To the Editor:

The editorial by Dr Cecil Wright on electrosurgery (*Wright VC. Contemporary electrosurgery: physics for physicians. J Fam Pract 1994; 39:119–22*) is well written and a fine contribution to the family medicine literature. It is delightful to have such a well-respected contributor to *The Journal of Family Practice.*

Dr Wright reports that "as many as 25% of patients [managed by the see-and-treat method] who have had excisions actually are found to have no disease, meaning that they have been unnecessarily subjected to a surgical procedure." This conclusion needs further discussion. Is a "see and treat" plan inappropriate for a patient in whom Papanicolaou smear revealed high-grade SIL and in whom the lesion is easily seen on colposcopy? Should preconization biopsies that increase patient discomfort and cost be performed before loop electrical excision of the transformation zone (LEETZ) in these patients? Every LEETZ provider should clarify this point in their own treatment plan formulations.

While a "see and treat" management process may lead to a high overtreatment rate, some patients will also have false-negative histologic findings after traditional colposcopic triage with biopsy. It is well known that the reparative process following uterine cervix biopsy will alter histologic interpretation. Many times, all or most of the lesional tissue will be removed by the biopsy process. This will expectantly cause some conization specimens to show a histologic absence of intraepithelial neoplasia. Also, the immunologic response involved in tissue repair after cervix biopsy may alter or remove lesional tissue.

When laser vaporization of the cervix was first attempted, many investigators tried to remove only lesional tissue that was grossly present. While cone biopsy specimens of these selectively lasered uterine cervices may have shown little or no disease, there was still a high recurrence rate of CIN following selective laser vaporization. When the entire transfor-

mation zone was destroyed (the only effective treatment for CIN) by laser vaporization, treatment outcomes of laser were found to be as good as those of cryosurgery.

One would expect to find negative histology on cervix conization following colposcopically directed biopsy in a significant percentage of LEETZ samples. Proper colposcopically directed biopsy dictates that all suspected lesional tissue must be biopsied adequately. Some reparative change in the uterine cervical tissue following biopsy is expected.

Dr Wright's article is excellent. Traditional colposcopic triage should precede most LEETZ procedures with rare exception, and some false-negative histologic conization specimens will be seen after cervix biopsy.

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

I have reservations about routine loop excision for all patients with abnormal smears before traditional colposcopic examination, biopsy, and triage are carried out. I agree completely with the position that Drs Bonardi, Cecchini, Grazzini, and Ciatto expressed in their recent article (*Bonardi R, Cecchini S, Grazzini G, Ciatto S. Loop electrosurgical excision procedure of the transformation zone and colposcopically directed punch biopsy in the diagnosis of cervical lesions. Obstet Gynecol 1992; 80:1020–2*), and I can find no more lucid way to express my opinion about "see and treat" than to quote their December, 1992 paper:

> We do not advocate loop excision as the standard assessment for all cases of cytologic abnormalities, as suggested by other authors.[6,7,11] In agreement with Giles and Gafar,[12] we think that this policy would lead to overtreatment, which is unacceptable especially given that the long-term effects of loop excision on fertility and pregnancy are unknown. The fall in the precision of colposcopic diagnosis with the increasing number of practitioners, as claimed by Anderson,[7] should encourage better training, quality control, and centralization to expert centers, rather than justify a "see and loop" approach to colposcopy."

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CORRECTION

The October issue of *The Journal of Family Practice* featured a Prevention in Practice article that included information about how to obtain the **Put Prevention Into Practice Education and Action Kit**. One of the telephone numbers listed was intended to be the toll-free number for the American Academy of Family Physicians ordering department. Unfortunately, the published number is for a sex hotline.

The correct telephone number for the AAFP ordering department is **1-800-944-0000**. We are sorry for the error and for any inconvenience this may have caused our readers.