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VASECTOMY TECHNIQUE FOR NORPLANT REMOVAL

To the Editor:

A 35-year-old woman required removal of a Norplant device (inserted by another practitioner) because of migraine headaches. Five capsules were removed from the expected fan-shaped array, but the 6th capsule was located 2 cm lateral to the others overlying the muscle at the medial edge of the biceps. The skin moved freely over the capsule, indicating it had been inserted too deeply. It could not be removed through the original incision so the operator deferred removal to a later date.

The patient returned in 2 weeks. Before making an incision, attempts to raise the proximal end by pushing on the distal end were unsuccessful. For this reason, the operator thought it would be difficult to use the recommended technique of maneuvering a curved clamp under the proximal end to grasp it. Remembering a vasectomy technique used to acquire the vas, he passed a 1.5-in. 22-gauge needle bent into a curve (and attached to the anesthetic syringe) under the capsule. Using this as a lever, he was able to raise the capsule and fix it through the skin with a towel clip.

The physician attempted to encircle the implant with a clamp used for nascalpel vasectomies, but the skin on the arm would not allow it. Instead, he encircled the implant with a second towel clip, which was then rotated to bring the implant up under the skin, tenting it. It could be easily palpated under the skin, similar to the vas during a vasectomy. Using vasectomy technique again, a No. 15 blade was used to cut down to the implant and release it. The wound was closed with sterile strips.

*Gil Soloman, MD
Canoga Park, CA*

ASTHMA: PALPATION AND INJECTIONS

To the Editor:

I entered private practice in 1956. I had been in practice only a short time when a few patients whom I had treated

for various pain problems by steroid injection therapy returned to report that they were no longer bothered by asthma. Soon there were 15 such patients. I pulled their charts, noting for each the anatomical structure injected, searching for a common denominator. I found it in the infraspinatus muscles of the infrascapular fossae.

With this knowledge, I then approached the average asthmatic patient with new interest. Part of my regular routine in examining asthmatic patients with no subjective complaints of pain other than the distress of their asthma became palpation of the infrascapular fossae. To my amazement and theirs, the infrascapular fossae were painful in almost every asthmatic patient I examined.

I explained to them the phenomenon of the apparent asthma cure by steroid injection, and I offered them the same therapy. Virtually all agreed to the injections, with the result that, to the very last one, their asthma was put into instant remission. They no longer wheezed or required ongoing medication and inhalers to breathe. Were they cured? Well, if you use the same standard as for cancer cure (5 years without a recurrence), then yes, you must conclude that these asthmatics were cured of asthma.

I have been in the practice of medicine now for 40 years. I am 67 years old. I do not know how much longer I will be able to remain in the active practice of medicine. I feel a sense of urgency to disseminate my knowledge to all my colleagues.

*Harry H. Philibert, MD
Metairie, Louisiana*

The preceding letter was referred by the editor to David L. Hahn, MD.

With regard to the letter from Dr Philibert, as someone once said, it's so crazy, it just might be true.

I reviewed a couple of books on acupuncture and, as I recall, there is indeed an acupuncture point in the upper back reputed to be involved in the treatment of asthma. It is not exactly located in the infraspinatus area, but is more medial to the scapula, above the rhomboid area,

and there are a number of other such points in other parts of the body.

It was also interesting to note that several of the acupuncture points said to be effective against asthma were the same ones said to be effective against bronchitis.

*David L. Hahn, MD
Madison, Wisconsin*

Information from the previous letter was referred to Dr Philibert, who responds as follows:

The observation of the *Journal's* expert in asthma was quite accurate. I recently returned from China as a part of the People to People Ambassador group delegation. In Beijing at the Traditional Hospital, I asked Dr Kiu Jincheng, Deputy Chief Physician and Associate Professor, about the treatment of asthma with acupuncture. On a blackboard, he drew the torso of a body and put a point bilaterally just above the rhomboids. In addition to dispensing herb medicines, they use acupuncture needles in these spots.

The injection therapy I use consists of isolating a specific painful anatomical structure, identifying it, and then injecting with a 1% hydrocortisone acetate solution in 0.5% lidocaine hydrochloride. To make such a solution: to a 50-cc bottle of 0.5% lidocaine hydrochloride, add 2 mL of 25 mg/mL hydrocortisone acetate. The solution is stable, and once mixed, has a shelf life of at least 6 months. Holding in one hand a 2-mL syringe that has a 1.5-in. 25-gauge needle on it, the physician palpates the painful anatomical structure with the fingers of the other hand. The needle is introduced through the skin immediately adjacent to the palpating fingertip. A small amount of the mixture is injected when the needle is introduced until the bone of the infrascapular fossa is encountered. The solution is then injected slowly as the needle is gradually and slowly withdrawn. A second syringe and needle is similarly introduced until bone is encountered, and half of the solution is injected proximally and distally to the first injection along the length of the infraspinatus muscle.

The infraspinatus muscle is immediately re-palpated. If the injections are suc-

cessful, no pain or tenderness whatsoever is present. If there is still any pain or tenderness remaining, then the structure must again be injected.

In 14 days, the patient with asthma is seen again and reevaluated. Most asthmatics are clear to auscultation at this time. The infrascapular fossa is again palpated. If it is still painful to palpation, it is injected in the manner already described.

The patient is reevaluated and reinjected in this manner at no less than 2-week intervals until all pain and tenderness is abolished. As the patient progresses, the interval between examination and re-injection is lengthened to 3 and, finally, 4 weeks. It is quite often reported by patients between their second and third visit that they voluntarily stopped taking their theophylline tablets as they no longer coughed, wheezed, or were short of breath.

It is this criterion that must be met for at least a year before a remission of this sort can be classified as a cure. There are many 5-year cures in the author's practice, insofar as the patients do not experience asthma attacks and do not require ongoing medication to prevent or control their asthma.

Harry H. Philibert, MD
Metairie, Louisiana

CIRCUMCISION DEVICES

To the Editor:

Circumcision is one of the oldest surgical procedures. In neonates of Jewish and Moslem faith, removal of the prepuce is almost universal. In the United States, this procedure has a prevalence of 59% to 90% despite recommendations of the American Academy of Pediatrics against it.^{1,2} The most common instruments used for removal of the foreskin in North America are the Gomco clamp and Plastibell device.³ This report familiarizes the physician interested in circumcision with the Winkelmann clamp and compares the degree of satisfaction with either the Gomco or the Winkelmann among family physicians familiar with both.

The Winkelmann is made of three parts, has a vertical configuration, and does not require disassembly during the circumcision operation. The Gomco has a horizontal configuration and four parts, apparently making it more difficult to handle (Figure). We tested this hypothesis by sending a questionnaire to family physicians who were familiar with both

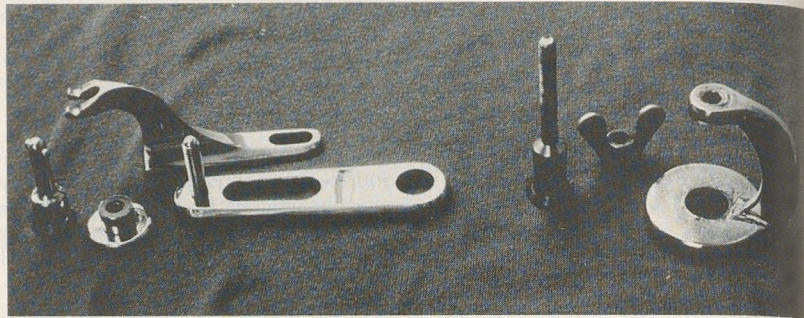


Figure. The four parts of the Gomco clamp (left) and the three parts of the Winkelmann clamp (right).

instruments and could compare their complication rates.

A pilot-tested self-administered questionnaire was distributed to all 61 primary care physicians practicing circumcision in Bahrain health centers. Those familiar with both the Gomco and Winkelmann clamps were asked to describe the parts of each on a sketch, state which clamp is easier for them to handle, and list the parts of the instrument that make it easier or harder to use.

All infants presenting to five health care centers between May 1 and July 31, 1992, for their second well-baby visit were examined by five nurses for late complications from the circumcision operation. The medical records of these infants were reviewed for early complications, the device used in the operation, and the age at which the baby was circumcised.

Of the 61 physicians performing circumcision in the Bahrain primary health care centers, 29 were familiar with both instruments. Nineteen were trained in the use of both, three for Gomco only, and seven for Winkelmann only. The frequency of performing circumcision in this group ranged from one to three per week, and the years of experience between 1 and 7. The Winkelmann clamp was reported to be easier to handle by 22 physicians (76%). The other 7 physicians found both the Winkelmann and the Gomco equally easy to use. None of the physicians reported problems with the Winkelmann clamp. Ten (34%) noted difficulties with Gomco's plate handling, and 18 (62%) with Gomco's nut mechanism. Winkelmann clamp assembly was favored by 21 (72%).

During the study period, 495 infants were circumcised at the health care centers. Of these, 383 (77%) were circumcised with the Winkelmann and 112 (23%) with the Gomco. The average ages

at circumcision were 42 and 38 days for the Winkelmann and Gomco, respectively. The complication rates for the Gomco and Winkelmann clamps were 1.8 and 2.0, respectively ($\chi^2 = 0.6$, $P = NS$). Of the 112 procedures performed using the Gomco, there was 1 case each of bleeding and little skin removed. Of the 383 using the Winkelmann, there were 3 instances of bleeding, 2 of infection, and 3 of little skin removed. None of the cases examined had evidence of meatal stenosis, adhesions, or injury to the phallus.

In communities where circumcision is common, physicians need to familiarize themselves with devices available for the minor operation. Based on the findings of this study, the Winkelmann is a suitable device for circumcision.

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POSTREJECTION PARONYCHIA

To the Editor:

A 43-year-old male physician returned home after a particularly grueling day at the office. When he opened the front door, he discovered a standard 9 1/2 x 12 manila envelope (American School

Co, Bayshore, NY) lying on the floor. The envelope contained a manuscript that had been rejected by the *Journal*.

Approximately 30 seconds after the envelope was opened, his wife heard a desk drawer slam shut, a bloodcurdling scream, and a barrage of unprintable expletives. Two days later, a 7-mm paronychia developed on the physician's right index finger. Treatment consisted of warm soaks and a 5-day course of cephalixin.

Physicians whose manuscripts get rejected by the *Journal* should consider other ways of venting their frustration. Possible examples include yelling at managed care administrators, arguing with drug reps, and refusing to attend any hospital committee meetings. Alternatively, one could keep a supply of Xanax on hand at all times.

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COMPUTERIZED SAMPLING TECHNIQUES

To the Editor:

It seems obvious that the increasing use of computers in general practice is an advantage for general practitioners, managers, and researchers in performing tasks such as medical audits. If this is really so, how big is the supposed advantage? By chance, we had an opportunity to gather some evidence.

In the scope of chart audit, we had to take random samples from the patient population in 20 general practices. Ten practices happened to record all patient data in a practice computer (*Metsemakers JEM, Höppener P, Knottnerus JA, Kocken*

RJJ, Limonard CBG. Computerized health information in the Netherlands: a registration network of family practices. Br J Gen Pract 1992;42:102-6), while the other 10 were still using traditional recording on cards.

We measured exactly the time needed to obtain the sample data in both situations. Afterward, we calculated the number of names that could be registered per hour. The size of the sample to be taken was set at 17% of the adult population in each practice up to a maximum of 400.

For *manual sampling*, we calculated the number of cards to be examined per unit in each practice by dividing the planned number of patients needed for the sample by the number of units stored in drawers and card-trays. We started at the front of each unit by taking the first card randomly and proceeded until we had reached the calculated number of selected cards per unit. The first patient that met the age criterion was included in our sample, followed by every fourth eligible patient. Names and addresses of the selected patients were registered in a portable computer using the label-function of a text editor.

For *computerized sampling* in 10 automated practices, using the general practice computing system "microHIS," it took 2 hours to adapt the available standard query procedure to our specific requirements for the computerized selection procedure. This specific research software dealt with the selection of the target group, systematic sampling, recording results, and producing lists and labels identifying the patients included. In addition, it marked the records with a code of all patients selected in order to make them easily accessible for follow-up.

Taking the computerized samples required only one twelfth the time needed in the manual procedure (7.5 vs

89 hours). When we consider the total number of sampled patients in the computerized practices (3505 vs 3035) the difference is even greater, with computerized sampling being 13.7 times faster.

The observed advantages of computerized random sampling can be summarized as follows. The computerized method seems more effective in covering the population because it lacks the division in units that was necessary in manual sampling. Next to the obvious time gains, there is researcher-friendliness (searching cardfiles manually is not an inspiring job for humans; computers don't mind), and minimal disturbance of daily practice routine. Patients can be protected against being selected too often for research projects because their record can be marked with a code. Administrative data in computerized practices are mostly correct. Patients are inclined to propose corrections on the spot whenever they detect incorrect data on the screen or on the header of their prescriptions. Moreover, computerized transfer of data excludes typing mistakes.

Inability to obtain the desired sample due to incomplete information in the computerized patient registration system is a possible disadvantage. Noncomputerized practices should not be excluded from a research study, since this could threaten the study's validity and generalizability.

We conclude that the computerized procedure was more efficient, almost 14 times faster, and quite gratifying for all people concerned.

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