

WHO IS A "SPECIALIST"?

To the Editor:

The February special issue of *The Journal of Family Practice* on primary care had a recurring and glaring problem: family physicians were referred to as primary care physicians (PCP) while other physicians were called "specialists."

Every time a family physician is referred to as a PCP or other nonspecialty title, we suffer discrimination. Such derogatory titles can easily be incorporated into conventional language, which results in less professional fulfillment. On January 1, 1996, the Health Care Financing Administration (HCFA) reduced primary care reimbursement through Medicare by 2.3% while raising payment for surgical services by 3.8%.

I begrudgingly spend hours a week trying to convince newcomers to managed care that it is okay to let me attend to their chronic illness. When local managed care groups distribute thousands of fliers calling me a PCP and refer to my consultant colleagues as "specialists," I find it harder to keep people from their requested but inappropriate referrals. If you could see a "specialist" for the same co-payment as you could see a "generalist," would not your first reaction be to get the most for your money? Since everyone knows that specialists cost more than generalists, would it not also follow that seeing a specialist was equivalent to getting more? To the unknowing, is more not better?

We must do everything we can to keep primary care specialties linked with mainland specialty medicine so no one confuses the quality of primary care provided by physician specialists with primary care provided by other health care workers (eg, nurses, chiropractors, and social workers). We must insist that managed care literature refer to primary care specialists as "specialists" and consultants as "consultants." We must insist that peer-reviewed literature dedicated to family medicine not condone any language that differentiates primary care physicians from other specialists, except in their respective areas of professional expertise.

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PATIENT SUPPORT NETWORKS

To the Editor:

Dr Camosy has provided an excellent list of patient support networks.¹ There are two additional resources that clinicians and patients should consider.

The National Library of Medicine maintains the DIRLINE database, which contains information on "more than 15,000 organizations that act as information resource centers."² The DIRLINE database can be searched using *Grateful Med* or other MEDLARS search tools. A quick and inexpensive search will produce a list of valuable support organizations for almost any condition. In addition, World Wide Web search engines, such as Alta Vista,* provide web links for an equally wide variety of conditions. Many of these web pages belong to the organizations Dr Camosy listed, and others may represent a uniquely personal perspective. The quality of information varies, and a clinician's perspective may be beneficial.

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2. Grateful Med Help File. Washington, DC: National Library of Medicine, 1995.

PARENTAL GRIEVING AFTER INFANT DEATH

To the Editor:

The few studies that have evaluated mothers and fathers who experience infant loss all draw the same conclusion: grief intensity is stronger in the mother than in the father. Grief, however, is never measured with a standardized grief measure. Therefore, we invited 13 un-

selected, consecutive couples whose infants were admitted to the Paediatric Surgery Intensive Care Unit at the Sophia's Children's Hospital Rotterdam because of major congenital anomalies to participate in a study. Six months after each infant's death, we asked the parents to independently complete the Perinatal Grief Scale (PGS) (Potvin L, Lasker J, Poedter L. *Measuring grief: a short version of the Perinatal Grief Scale. J Psychopathol Behav Assess* 1989; 11:29-45).

The major anomalies among this group of infants were multiple anomalies (n=2), cardiac anomalies (n=3), diaphragmatic hernia (n=1), status quo after kidney transplantation (n=1), esophageal atresia (n=2), meconium peritonitis due to cystic fibrosis (n=1), tracheal atresia (n=1), and necrotizing enterocolitis (n=2).

The age of the parents ranged from 18 to 37 years (median, 28 years), and the age of the infants at the time of death varied between 0 days and 12 months (median, 30 days). To our surprise, and in contrast to the findings of other studies that found more intense grieving in mothers, there were no significant differences in PGS scores between mothers and fathers. Further, the correlations between the mothers' and the fathers' subscales and total scores were low, ranging between .20 and .50 (a shared variance of 16% to 25%), indicating that parents do not grieve in the same ways or over the same time.

We conclude that after infant loss the grief intensity of fathers is equal to that of mothers, but that, within each couple, the mother's and father's ways of grieving are incongruent. Our hypothesis is that mothers and fathers cope differently with the loss of an infant. Future studies might focus on the underlying processes to explain the divergent aspects of grief between fathers and mothers.

These results are likely to increase health care professionals' awareness of the grieving process and may lead to improvements in support for bereaved parents, in particular for the father. The father should be regarded not only as an intermediate between the physician and the mother, which is generally the case, but also as a person with individual

*Produced by Digital Equipment Corporation. Alta Vista's website address is: <http://www.altavista.digital.com>

emotional needs that follow a specific course.

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PANIC ATTACK OR CVD?

To the Editor:

The differential diagnosis of panic symptoms presents problems for both primary care physicians and psychiatrists, primarily because the diagnostic criteria¹ for a panic attack emphasize many of the symptoms found in cardiovascular disease. These include nausea, shortness of breath, chest pain, dizziness, palpitations, sweating, paresthesias, and fear of dying. Since patients with panic attacks visit emergency rooms 12 times more frequently than the general population,² and since panic and other anxiety disorders are present in 10% to 83% of patients who have concurrent medical conditions,³ there is ample opportunity for diagnostic error.

Consider the case of a 75-year-old married veteran with a history of panic attacks dating to World War II. After the war, he developed recurrent depressive episodes, and later, hypertension and arteriosclerotic cardiovascular disease. One year prior to the present episode, an echocardiogram revealed an ejection fraction of 55%, mitral regurgitation, and aortic insufficiency. A 3-vessel bypass graft was performed after angiography demonstrated significant obstructive disease. Several months following surgery, his depression and anxiety worsened. He was given alprazolam 0.5 mg twice daily and fluoxetine 20 mg once daily, in addition to nifedipine 120 mg/d and isosorbide 60 mg three times daily. In psychotherapy, he began to focus on themes of death and war trauma, and he appeared to be less anxious. Several days after a psychotherapy session, however, he called the emergency room to report worsening anxiety, tremulousness, and shortness of breath. Over the next 2 hours, the resident psychiatrist, who had been in family

practice for some years, recommended an additional 1.5 mg of alprazolam and 50 mg of diphenhydramine. There was no improvement. At 2:00 AM the patient and family came to the ER; *all agreed that this episode was similar to past panic attacks.* The resident agreed; no physical examination or laboratory studies were conducted. Lorazepam 1 mg was given intramuscularly, followed 1 hour later by 50 mg of hydroxyzine, but his symptoms persisted. Auscultation of the chest then revealed diffuse rales and scattered wheezes. A chest film indicated pulmonary edema. He was admitted for intravenous furosemide, which led to rapid improvement.

Diagnostic approaches to the patient with anxiety have often focused on the following dichotomy: does the patient have a primary psychiatric disorder *or* a medical disorder?⁴ In this approach, the chronology of disease becomes important, and some have advised that the sequence of illness be confirmed by family members.⁴ In this case, however, not only was the sequence of illness well established, but the family and patient agreed that the present symptoms were those of a panic attack. Unfortunately, these data were quite misleading, and led to a delay in applying the most fundamental of diagnostic tools: a physical examination.

In patients with comorbid medical and psychiatric disease, reliance on the "either-or" dichotomy and the chronology of illness can be misleading. An early physical examination and appropriate laboratory studies are absolutely necessary if potentially fatal errors are to be avoided.

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ACUTE DIVERTICULITIS AND OBESITY IN YOUNG ADULTS

To the Editor:

During my 31 years of gastroenterology practice, I have not seen a case of diverticulitis in someone under 30 years old. However, I was recently a defense witness in a case illustrating that diverticulitis is far more common and far more vicious in a particular population: obese young adults. The emphasis of this report is awareness, since such cases invariably present first to family physicians and emergency room physicians.

In this case, a 25-year-old morbidly obese man with lower abdominal pain and acute constipation saw a number of clinic physicians over 10 days before he presented to the hospital emergency room with acute devastating lower abdominal pain. A complete blood count was near normal. He was too large for the computerized tomographic (CT) scanners. A Gastrografin enema was performed to detect appendicitis. The sigmoid was hypermuscular and diverticula were not seen, but after cecal filling, right gutter air and contrast appeared, indicating a perforation. At surgery, acute peritonitis and ruptured abscess cavity from sigmoid diverticulitis was found. Still intubated, he died of sepsis and multi-organ system failure, a few hours after the difficult 6 1/2-hour operation.

Konvolinka¹ from the Guthrie Clinic and Schauer's group² published a series of acute diverticulitis cases in surgery journals, emphasizing four features that were also seen in the patient mentioned above: almost universal obesity, particularly "morbid" obesity; atypical localization of pain and tenderness (44% did not have lower left quadrant pain, although in 82%, the diverticula were limited to the sigmoid); preoperative misdiagnosis in 50%; and a virulent course with a high percentage of emergent surgeries.

Very obese patients should be educated that too many pounds deprive them of today's diagnostic technology. Being too heavy for angiographic tables, exceeding CT scan weight limits or magnetic resonance imaging dimensions, and compromised marginal visualization on routine contrast radiographic and ultrasound become a tragedy, as in this case, limiting physicians to their brains, hands, and a "dousing" stick. Correct diagnosis and intensive antibiotics might have obviated emergent surgery. The radiographic complication that occurred with

this patient, a reason to avoid initial barium, is often feared but rarely occurs. Everyone involved in this patient's care thought he weighed over 450 lb, but, even though there was a scale weighing to 800 pounds on his ward, he was never weighed! Since conventional scales weigh a maximum of 300 to 350 lb, most morbidly obese patients do not know their own weight. Retrospectively, lawyers in this case were quick to "shrink" the patient and then question why he did not have a CT scan and other diagnostic tests. One lesson emerging from this experience is that if a patient's weight precludes a particular diagnostic study, document the weight. After prolonged angst, the family physicians, emergency room physicians, gastroenterologist, and hospital involved with this patient each settled with his parents for significant compensatory sums.

Similar patients will undoubtedly present to you. In most young men with acute abdominal signs suggesting the need for surgery, appendicitis ranks No. 1 through No. 10 as a diagnosis. With morbidly obese patients, however, do not forget diverticulitis: a typical appendectomy incision portends a complex time!

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Tips from Practice

Do you have a practical solution to a common problem faced by family physicians? If so, share it with fellow readers of *The Journal of Family Practice*.

Tips from Practice should be 250 to 500 words in length, typed, and double spaced. Address to *The Journal of Family Practice*, 519 Pleasant Home Road, Suite A-3, Augusta, GA 30907.

Tips from Practice

ACLS Mnemonics

The following mnemonics were developed over years of instructing and directing Advanced Cardiac Life Support (ACLS) courses. They offer a common ground for students who must learn the material in short periods of time and keep it handy for the practice of resuscitation medicine in harrowing emergencies.

Much of medicine is memory work. What we memorize in a certain order, we remember in that order. Mnemonics or "memory devices," from the Greek word *mimnesko* (I remember), simplify the task of recalling large amounts of material by effectively summarizing it in nonsensical ("on old Olympus' terraced top . . ."), or naughty ("never lower . . .") little ditties. Hard to forget the cranial nerves or carpal bones, isn't it?

It is hoped that when, in the words of an old song, "you must remember this," these simple devices will come to your rescue!

ACLS Mnemonics

Asystole Protocol:

Algorithm: "PEAT"

Pacer—consider a pacer first
Epinephrine
Atropine
Terminate

Asystole Causes:

"**H**ubert **H.** Humphrey
had asystole!"*
Hypoxia
Hypothermia
Hypokalemia
Hyperkalemia
Acidosis
Drug overdose

Bradycardia Protocol:

"First Atropine, Then a
Pace Machine"

Pulseless Electrical Activity Protocol:

"**O**, Patch **A** PEA"*

Overdose
Pulmonary embolism
Acidosis
Tension pneumothorax
Cardiac tamponade
Hypovolemia, hypoxia, hypothermia,
hyperkalemia
Acute myocardial infarction
= Pulseless **E**lectrical **A**ctivity

Ventricular Fibrillation Protocol:

"Shock, shock, shock. Everybody shock.
Little shock. Big shock. Mama shock.
Papa shock."

Or

"Dance. Dance. Dance. Everybody
dance. Little dance. Big dance. Momma
dance. Poppa dance."

For

"Defibrillate. Defibrillate. Defibrillate.
Epinephrine—Defibrillate. Lidocaine—
Defibrillate. Bretylium—Defibrillate. Mag-
nesium—Defibrillate. Procainamide—
Defibrillate."[†]

Tachycardia Protocol:

"Pulse and awake, drugs they must take.
Pulse and a nap—zzzaaapp!"

Paroxysmal Supraventricular Tachycardia Protocol:

"Either adenosine wins or the thrill be-
gins!"

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*Devised by the author. The remaining are reworked older mnemonics.

[†]An old mnemonic, modified by Kathy Hovey, RN, Lansing Community College, Lansing, Michigan.