LETTERS TO THE EDITOR

NEONATAL CIRCUMCISION

To the Editor:

Prolonged hospital stays resulting from infant male circumcision[1] may only increase as perinatal hospitalizations continue to shorten. A recent case at our institution exemplifies this.

A boy was born vaginally at 37 weeks' gestation to a 31-year-old gravida 3 para 3 mother. The neonate, who had Apgar scores of 8/9 and a birthweight of 2890 g, developed grunting, flaring, and intercostal retractions at 5 hours of age. A chest radiograph confirmed transient tachypnea of the newborn, and he was placed on oxygen. He was weaned to room air by 10 hours of age. At 20 hours of age, he was circumcised by the obstetrician. Following the procedure, the baby had difficulty nursing, which resulted in a weight loss to 89% of birthweight (2595 g). By the fourth day, the baby began to nurse well and was discharged.

Newborn males respond to circumcision with a marked reduction in oxygenation during the procedure,[2] and a cortisol surge,[3] decreased wakefulness,[4] increased vagal tone,[5] and less interactions with their environment[6] following the procedure. All of these factors hinder the maternal-infant bonding process that makes breast-feeding possible. With shortened perinatal hospitalizations, there is a rush to have boys circumcised within 24 hours of age to facilitate timely discharge. The health of the boy is often secondary, as demonstrated by the short time from weaning to room air and the performance of the circumcision procedure. The degree to which circumcision adversely affected this baby's ability to nurse is not clear, but it may be partially or completely responsible for the "prolonged" stay.

Not too long ago, male infants were routinely circumcised in the delivery room. This practice was discontinued only after the adverse effects were published.[7] With shortened perinatal hospitalizations, will we regress toward delivery room circumcisions? In 1989 the American Academy of Pediatrics stated that: "Circumcision is contraindicated in an unstable or sick infant. . . .Infants who have demonstrated an uncomplicated transition to extrauterine life are considered stable. Signs of stability include normal feeding and elimination and maintenance of normal body temperature without an incubator or radiant warmer. A period of observation may allow for recognition of abnormalities or illnesses (eg, hyperbilirubinemia, infection, or manifest bleeding disorder) that should be addressed before elective surgery."[8] If one follows this standard in an era of 24-hour perinatal hospital stays, are inpatient neonatal circumcisions possible?

Robert S. Van Howe, MD
Marshfield Clinic, Lakeland Center
Minocqua, Wisconsin

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ACRONYMIA

To the Editor:

Acronymia is not alway the benign condition that Drs Shaftner and Meehan describe in their humorous column.[1]

As a medical librarian whose job includes helping physicians locate information from clinical trials, I have often wondered what the logic could possibly be behind some of the names. A trial that is named so that the acronym forms a common English word will be difficult to find in the literature. TIMI and GISSI and MRFIT are excellent names—easy to remember, and not easily confused with anything else. On the other hand, trials named CARDIAC, IMPACT, and SUPPORT are very hard to find in databases such as MEDLINE because their names are such common words. Unless you know what IMPACT stands for (and there are three *different* trials with this name[2]), you will have to slog through many trials on the intervention you are interested in, and the word "impact" will be of no help. Even worse are the trials with names that are known as "stop" words—words that are so common that MEDLINE considers them to be useless and not searchable at all. For exam-

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ple, you cannot search for the words THIS, THAT, or WHAT in MEDLINE, but these are all trial acronyms.

Jennifer Reiswig, MLS
Health Sciences Library
Toronto East General Hospital
Toronto, Ontario

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2. Cheng TO. Acronyms of clinical rials in cardiology 1994. Am J Cardio 1994; 74:79-94.

To the Editor:

Dr Shaftner and Meehan are absolutely correct in their observation that "a really good study has to have a really good name to make a splash on the scientific horizon." Accordingly, I spent long hours searching for the appropriate acronym for a study that compares three preparations for flexible sigmoidscopy.* I ultimately decided on the following:

CRAPS: **C**learance **R**ates **A**fter **P**rep for **S**igmodoscopy

But I also toyed with the following:

FART: **F**leets **A**lters **R**ates of **T**ransit

POOP: **P**reparation **O**rdering **O**ptions for **P**roctosigmoidscopy

FECES: **F**leets **E**valuation in **C**olon **E**mptying for **S**igmoidscopy

STOOL: **S**igmoidscopy **T**rial: **O**bservations of **L**axatives

I rejected the following as too risque:

SHITS: **S**tudy of **H**ypertonic **I**nduced **T**ransit for **S**igmoidoscopy

Gil L. Solomon, MD
Canoga Park, California

MNEMONICS

To the Editor:

We were entertained to read Dr Webb's ACLS mnemonics *(Webb CW. ACLS mnemonics. J Fam Pract 1996; 42:624)*. Having recently completed the ACLS instructor program, we would like to share a few mnemonics that we have found helpful:

Pulseless Electrical Activity (PEA) Protocol

P = **P**robable Cause

Three up (H+ concentration/acidosis; drugs levels/OD; hyperkalemia)

Three down (hypothermia, hypovolemia, hypoxia

Two needles (pneumothorax; tamponade)

Too (2) bad (MI, massive PE)

E = **E**pinephrine

A =**A**tropine

Bradycardia = Bradeecardia

B = **B**asics (ABC's, IV, O_2, monitor)

R = **R**ace to Pace

A = **A**tropine

D = **D**opamine

E = **E**pinephrin**E**

We find these simple aids extremely effective for personal recollection as well as good devices for teaching students.

Mark B. Stephens, MD
Naval Hospital San Diego
San Diego, California
Robert F. Wilson, DO
Naval Hospital Bremerton
Bremerton, Washington

POEMs, DOEs, and PROSE

To the Editor:

"All that is not prose is poem; and all that is not poem is prose."[1] Doe "the female of the deer or almost any other animal the male of which is referred to as a buck."[2] Doe is clearly not the opposite of poem, prose is.

POEMs have become an accepted shorthand for important papers in the medical literature, thanks to the work of Slawson and Shaughnessy.[3,4]

Building on the work of the McMaster's group on evidence = based medicine and through their writing and speaking, Slawson and Shaughnessy are proselytizing to all of us in family medicine. One of their major contributions has been to develop the acronym POEM for **p**atient **o**riented **e**vidence that **m**atters. There is no need to read a published report to see how well done the research is if it does not meet the criteria of being patient oriented and making a difference, ie, a POEM. It is no wonder that in our journals and our daily work we are now constantly querying "but is it a POEM?" On the other hand, the putative opposite DOE, **d**isease **o**riented **e**vidence, has not caught on and is rarely used.

I propose that the true opposite of POEM is PROSE, papers reporting only scientific evidence. The operative term is "only," meaning the absence of patient orientation. The first step in reading an article is to determine whether it is a POEM or PROSE. PROSE should be evaluated for quality and usefulness only if POEMs do not exist. POEMs still need to be evaluated for meeting established scientific standards. Whether good PROSE is better than a bad POEM will be the subject of another communication.

Joel H. Merenstein, MD
Lawrenceville Family Health Center
Pittsburgh, Pennsylvania

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*Study to be presented at the 1996 Annual Scientific Assembly of the AAFP, New Orleans.