Under My Skin

'I Googled You'

BY ALAN ROCKOFF, M.D.

When I started my practice, patients found me through the Yellow Pages. "I recognized your address," they said, or "You were convenient." It seemed a little impersonal, but what could I expect? I was new.

Later, patients found me on HMO lists. Their physicians referred them because I was the only dermatologist on the rosters at the time, my older colleagues having refused to join. I dutifully sent referral letters to physicians I didn't know: "Dear Doctor: Thank you for referring Jane. I am treating her acne with such-and-such." Perhaps they read them.

As my fame and reputation grew, I began getting referrals from doctors' receptionists. "They gave me a list," patients would say. "'Here are the three dermatologists we use.' The lady at the front desk suggested you." An article I once wrote for a medical magazine was titled, "My Doctor's Receptionist's Hairdresser Sent Me Over."

I understood all this. Even before our field became synonymous in the public mind with Botox and cosmetic fluff, nondermatologists thought of skin diseases as something exotic and superficial ("It's one of those skin things. Go see a skin guy."), if not alien and frightening ("Lordy, it's one of those skin things! Go see a skin guy!").

I could be wrong, but I can't imagine similar referrals to other specialties. ("Your ticker is tocking. Go see a heart guy.") In any case, even when patients have come from other physicians, I have rarely felt a sense of the real collegiality I imagine takes place in hospital corridors and cafeterias. Once in a great while over the years, I've gotten an urgent call from a doctor in my own building eager to send down a patient with a dramatic rash, and I've even gone upstairs myself while the patient was still with the internist or surgeon. Such occasions have been uniquely satisfying, though rare enough that I can actually remember them.

Now that I've been around for a long time, many of the doctors who used to refer patients to me, one way or another, have retired, slowed down, or gone concierge. Also, more people have PPOs that don't require physician referral. As a result, when I ask, "Who referred you to me?" I'm apt to hear, "I looked you up online on my insurer's Web site, and I recognized your address. You were convenient." Higher tech, but familiar.

Sometimes people are referred by other people. "I got your name from a friend," they'll say.

"Neat. Which friend?"

"Uhhh … actually, I think it was my mother-in-law's friend."

Then of course there's Google. "I did an Internet search," a new patient says.

"No kidding," I reply. "What did you search for?"

"Dermatologists in Brookline."

Makes you feel warm and fuzzy all over, doesn't it?

One patient was more flattering. "I Googled 'Top Dermatologists, Brookline.' "

Wow, I thought. I've been optimized.

I Googled that myself, and what came up first was an Internet Yellow Pages site with a list called "Featured Advertisers: Dermatology" on top, the first of which was an animal hospital, with an offer to "get coupon for pet's first visit!" Next to that was a listing for a (human) dermatologist in a town 20 miles north. Scrolling down past more advertisers and a long paragraph of skin-related keywords, I found actual dermatologists in Brookline. I came in second, with an incorrect address.

Just for fun, I Googled "Bottom Dermatologist Brookline." The top listing for that was an answer on a medical Web site that I wrote in 2005 to a worried questioner who had pimples on his bottom. Bottom's up!

Not long ago, I saw a patient who identified herself as a "health writer for the Wall Street Journal." After I examined her, she asked me for the name of an internist. "I need someone affiliated with a major teaching hospital," she explained. "In case I get sick, I need access to the most advanced medical care. I'm a sophisticated medical consumer," she added. "After all, I'm a health writer for the Wall Street Journal."

I gave her the names of two doctors. "By the way," I asked her, "how did you find me?"

"The mailman," she said. "I met him while I was walking by your building, and he told me he hears you're good."

Well, I am the only dermatologist in the building. ■

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Guest Editorial

New Teen STD Data Reinforce Annual Screening

BY STEPHEN I. PELTON, M.D.

Physicians need to do a better job of assessing sexual activity in adolescent patients, screening sexually active teens for sexually transmitted diseases, and counseling them about how to avoid becoming infected in the future.

Recently, a report of data from the 2003-2004 National Health and Nutrition Examination Survey (NHANES) revealed that one in four American teenagers had at least one prior sexually transmitted disease (STD). This should provide strong support for physicians to incorporate guidelines from the Centers for Disease Control and Prevention and the American Academy of Pediatrics into their practices.

The survey found that 26% of a nationally representative sample of 838 adolescent girls aged 14-19 years were infected with at least one STD, while 15% had more than one ("CDC: Over 3 Million Teen Girls Infected With STD," SKIN & ALLERGY NEWS, April 2008, p. 39). The analysis even excluded the prevalence of gonorrhea, syphilis, and HIV infections.

The data confirm that, although the rate of teen pregnancy has recently declined, adolescent sexual behavior remains prevalent. While I'm not aware of data regarding the reasons for the drop in pregnancies among teens, I suspect that it's due at least in part to increased use of birth control, as well as abortion, rather than a large shift away from sexual behavior.

Indeed, teenagers—and even some preteens—are having sex. Physicians need to ask adolescents if they are engaging in sexual behavior, and if so, to test them annually for STDs, screen for HIV, and counsel those who choose sexual activity about how to approach it safely and responsibly. And we need to start early. The CDC found that these infections, especially HPV, occur quickly after sexual debut. In fact, the STD prevalence was already 20% among those who reported just 1 year of sexual activity.

While there were racial differences—48% of black teens had at least one STD, compared with 20% of white teens—we should never assume that any early sexual activity is limited to specific racial or socioeconomic groups. This is an issue for every physician, whether you practice in an urban, suburban, small-town, or rural setting. Yes, some of your patients are at greater risk than others—but you can't be sure which ones without asking about sexual activity.

Screening should take place annually at routine visits as well as at acute care visits whenever possible. Particularly in the adolescent age group, I think we need to take advantage of every opportunity. Specifically, teens should be asked if they're sexually active, and if so, what kind of activity they engage in, whether it is with members of their own or the opposite gender, and whether they use barrier protection.

All sexually active teens should be counseled about the importance of condoms and their proper use. For a variety of reasons, condom use is currently quite low among adolescents. Teen boys often don't want to use them because they decrease sensitivity or simply aren't seen as "manly." An excellent resource for how to talk to teens about condoms is available at www.hws.wsu.edu/healthycoug/Men/condoms.html.

Sexually active females should be screened yearly for *Neisseria gonorrhoeae* and *Chlamydia trachomatis* using a cervical or urine GC/CT nucleic acid amplification test, with urine being the preferred method today. For males who have had sex with other males in the past year, an annual RPR (rapid plasma reagin) test for syphilis is recommended, along with annual pharyngeal gonorrhea cultures for those who have engaged in oral sex and rectal GC/CT swabs for those engaging in receptive anal intercourse. Although there are no specific recommendations for heterosexual males, we have learned that STDs can be asymptomatic. Personally I think screening is appropriate because it can be done easily with a urine specimen.

Recent CDC guidelines recommend that all sexually active individuals be screened annually for HIV, beginning at age 13. I endorse that recommendation, although many states have maintained the requirement for written informed consent for HIV testing, which places a barrier to proceeding. At least now all 50 states allow adolescents to sign their own consent forms without the need for a parental signature.

Although screening for HPV is not recommended, we can now offer the HPV vaccine to all of our female patients prior to sexual debut. Potentially, we will soon be able to offer it to our male patients as well.

Finally, I think we also should make an effort to encourage abstinence among our adolescent patients who have not yet embarked on sexual activity. I recently read an article about a female Harvard student who said she felt isolated because she had chosen to abstain from casual sex and decided to form a support group for like-minded young people. Contrary to popular belief, not every adolescent or young adult who chooses to abstain from casual sex or sex in general is of a strict religious or right-wing persuasion. Some have simply decided it's not right for them at this early stage in their lives. ■

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