Letters to the Editor

Health Screening

To the Editor:

I was delighted to see the article by Rasgon (Rasgon IM: Value of proctosigmoidoscopy in colorectal carcinoma. J Fam Pract 2:95-98, 1975) in the same issue as our discussion of screening for colorectal carcinoma (Frame PS, Carlson SJ: A critical review of periodic health screening using specific screening criteria. Part 2: Selected endocrine, metabolic and gastrointestinal diseases. J Fam Pract 2:123-129, 1975) – especially since our conclusions were somewhat different. One of the purposes of our paper was to stimulate objectively based discussion of screening procedures.

In this spirit, I should like to offer a few comments on Dr. Rasgon's article. First, I feel information crucial to the author's conclusion that routine proctosigmoidoscopies are valuable has been omitted. We are not told how many patients were examined, how many sigmoidoscopic exams were done on each patient, or how many cancers were detected on the initial examination versus follow-up examinations. Without this information, the data presented tell us only that "cancer prone" lesions were found in 0.8 percent of 1,900 random proctosigmoidoscopic examinations. It says nothing about the value of "routine" (ie, repeat) examinations. This information is also necessary to evaluate what is meant by 96 percent patient compliance.

I do not understand why Gilbertsen's study from the Minnesota Cancer Detection Center (Ref. #1) cited on page 97 was not included in Table 2. This was a large study of repeat proctosigmoidoscopies which found a low yield of one cancer per 6,100 examinations (0.016 percent). The paper then presents a dual argument to justify routine proctosigmoidoscopy: (1) from Gilbertsen's data, routine sigmoidoscopic exams are justified since a *low* yield of cancer proves removal of polyps prevents cancer; (2) from the author's data, routine sigmoidoscopy is justified since a *high* yield proves it detects a large number of cancers. This seems a bit like "having one's cake and eating it too."

Finally, no mention is made of the possibility that other methods such as testing stools for occult blood, might be as effective and a more convenient way than proctosigmoidoscopy to screen for colorectal cancer.

Paul S. Frame, MD
Dansville, New York

To the Editor:

On reading Dr. John P. Geyman's editorial (Geyman JP: Toward more rational health screening. J Fam Pract 2:83, 1975), I would like to further support his statement about screening being related to age, sex, genetics and risk factors in practice.

This idea is also put forth in this writer's article in the *Canadian Family Physician* (Rosser WW: The periodic health examination: A challenge for the family physician. Can Fam Physician 20[11]:80-83, 1974). In my own practice, I have found it helpful to utilize a form which puts in perspective the risk factors present so that both screening and health education needs of the individual patient can be made more clearly in perspective.

If family physicians better utilize our current knowledge of disease prevention and risk reduction, we will have better justified our existence in the health care system.

W. W. Rosser, MD
University of Ottawa
Ottawa, Ontario

Pediatric Lap Examination

To the Editor:

Smilkstein has described lap techniques for the examination of infants and small children up to four years of age (Smilkstein G: The pediatric lap examination. J Fam Pract 1[2]:66-69, 1974). Two aspects of his method depart from his stated goals for the technique and warrant further comment.

Rather than keeping the child totally unclothed throughout the examination, the physician should have the parent leave the child in its diaper or undershorts except for the portion of the examination related to the genitals and femoral arteries. It is unnecessary to subject the examining room, the clothes of the parents, and the clothes of the examiner to possible urine staining for the bulk of the examination time. The child should be spared the psychological trauma of "making a mess," and the office should be spared the inefficiency caused by unnecessary cleaning. Another undesirable feature of performing the entire examination while the child is completely undressed is the needless

prolonged embarrassment of the three and four-year-olds who have already developed feelings of modesty at home.

When Smilkstein finds the child or infant uncooperative for abdominal, oral, or otic examination, he abandons the lap position and has the child or infant moved to the examination table where maximum constraints can be applied much more easily. His examination techniques for these anatomical areas at the table are traditional; however, because the child or infant is still fully unclothed when moved to the table, the physician using Smilkstein's approach exposes himself or herself needlessly to possible urine staining of the chest. In addition, as illustrated in Figure 8 of Smilkstein's description, such an approach in psychological terms places the examiner in the position of a dominant adult authority figure making a forcible frontal assault upon the naked, unprotected genitals and body of a young child. Furthermore, in the eyes of the child the parent not only permits this assault but *assists* the doctor by constraining the arms. Any physician who accepts the Freudian stages of sexual development should be most hesitant to make such an approach to the unclothed child who is older than 18 months of age and in the Oedipal stage of sexual development. (Note the difference in the mother's facial expression in Figure 8 as compared with her expressions in all of the other photographs.)

Duane A. Lawrence, MD
Virginia Beach, Virginia

Care of Rape Victims

To the Editor:

The Family Practice Grand Rounds by Kaufman et al, from the University of New Mexico (Kaufman A, Hilaski S, DiVasto P, et al: Total health needs of the rape victim. J Fam Pract 2:225-229, 1975) has one recommendation for the prevention of venereal disease which is not up-to-date. It is no longer recommended that there be any waiting period between giving the 1.0 gm of probenecid and the 4.8 million units of procaine penicillin.[1] Otherwise, I thought the discussion and handling of the patient were excellent.

H. L. Muncie, Jr., MD
University of Maryland Hospital
Baltimore

[1] Center for Disease Control: Gonorrhea: Recommended treatment schedules. Ann Intern Med 82:230-233, 1975

The Family Physician as Counselor

To the Editor:

I was greatly disturbed by the April issue of your Journal. In the editorial guidelines it says that this Journal is interested in "advancing and defining the discipline of family medicine." This policy is well manifested by Drs. Schmidt and Messner in their article on divorce (Schmidt DD, Messner E: The role of the family physician in the crisis of impending divorce. J Fam Pract 2:99-102, 1975) when they encourage the family physician to "make a more significant contribution towards the preservation of the nuclear family." However, this goal is obviously ignored by Drs. Glasser and Pasnau in their article on adolescent abortion. (Glasser M, Pasnau RO: The unwanted pregnancy in adolescence. J Fam Pract 2:91-94, 1975) In that article they encourage "the family physician" to engage in subterfuge in order to aid the adolescent in obtaining an abortion without parental consent or knowledge. They even suggest that through the abortion procedure "she is able to develop self-esteem and individual growth – as an individual free from parents."

I suggest that you either change the name and editorial policy of your Journal or you omit articles which encourage disintegration of the family unit.

Robert D. Orr, MD
Brattleboro, Vermont

The above letter was referred to Drs. Glasser and Pasnau who reply as follows:

To the Editor:

In response to Dr. Robert Orr's letter concerning our recent article on "The Unwanted Pregnancy in Adolescence," we wish to correct what we feel to be an unwarranted interpretation of our views. Our experience has been that when an adolescent woman receives concerned, non-judgmental and supportive counseling from her family physician, the young woman turns to her parents for emotional support and assistance in the majority of cases. This counseling, which should include an opportunity to explore fully all of the alternatives available to her in solving this life crisis, most often facilitates the reconstitution and cohesiveness of the family. We do *not* in any way advocate the breakdown of the family.

We are concerned about those sad cases in which the adolescent is striving for an identity and finds it necessary to prematurely separate from her family, either physically or emotionally. Often this is due to a lack of understanding on the part of the parents of her growing need to function more independently in preparation for the assumption of an adult role. The disintegration of the family unit occurs when the young woman feels that there are no alternatives available to her except to pursue a nondirected impulsive course without family supervision. Such situations may lead to unwanted pregnancy. In numerous cases our guidelines have helped to facilitate the resolution of the crisis and have enabled the adolescent to return to her family as an active and healthy member.

Robert O. Pasnau, MD
Martin Glasser, MD
University of California
Los Angeles

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.