Letters to the Editor

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.

Treatment of Near-Drowning

To the Editor:

Regarding the "Self-Assessment in Family Practice" article on near-drowning (*J Fam Pract 5:877, 1977*), nasogastric decompression of the stomach should be included as one of the high priority procedures to be performed in a near-drowning situation.

There are three reasons nasogastric decompression is indicated:

1. To prevent mechanical interference with ventilation caused by large volumes of swallowed water[1]
2. To decrease the possibility of aspiration of gastric contents[2]
3. To prevent the gastrointestinal absorption of water which might result in dilutional hyponatremia.[3]

David B. Sills
Fourth year medical student
Office of Student Affairs
Baylor College of Medicine
Houston, Texas

References

1. Graves SA: Drowning and near-drowning. In Vaughan VC III, McKay RJ, Nelson WE (eds): Nelson Textbook of Pediatrics, ed 10. Philadelphia, WB Saunders, 1975, p 278

2. Gilfoil MP, Carvajal HF: Ne drowning in children. Tex Med 73(7):2 1977

3. Kohaut E: Near-drowning. P sented at Baylor College of Medic Pediatric Grand Rounds, Texas Childre Hospital, Houston, Texas, May 2, 197

Value of Routine Screenin Procedures

To the Editor:

I have two comments about th article, Screening During Routi Health Assessment, by Kirkwoo and Froom (*J Fam Pract 5:56 1977*). The first comment concer their methods, the second concer philosophy.

Their Methods: Inclusion in th study of several items involvi judgment makes the results diffic or impossible to interpret. This i cludes not just items like "soci history" but, strangely enou even the numerical data of certa laboratory tests. I could go throu their Table I ("Definition of Ab normality. . . .") item by item demonstrate this, but I will ju choose one point from each of th Procedure categories in that tabl

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a. Physical Examination: A particular heart murmur could be recorded as "functional systolic ejection murmur" or "grade 1/6 systolic ejection murmur." They would both be recorded as abnormalities, but one would be recorded as having been followed up, and the other not. Similarly, how would the authors have handled the recording of a "moderately" enlarged prostate in an asymptomatic 65-year-old man when there was no further comment in the chart?

b. Social History: An abnormality here is defined as the "presence of a situation amenable to intervention." In whose opinion? There is enormous variation between professionals as to whether intervention is practical or helpful in different situations.

c. Chemical Blood Screen: An abnormality is "a result deviating from a laboratory-established normal range." Physicians in practice know that the laboratory-established (statistically-derived) normal range is not always the "homeostatic" normal range nor the "actuarial" normal range. They may for very good reasons choose to consider that a result which is slightly outside the laboratory-established range is in fact normal. In that quite common case they are very unlikely to ask a secretary to spend time retrieving a chart, and spend their own time making a notation about a situation that they do not consider pathological anyway.

The above problems make it impossible for me to interpret the results of the whole study regarding the number of abnormalities and follow-up.

Philosophy: More important than the above, however, is the significance that abnormalities should be sought, and if found, should lead to some action. All this without proof that most of this costly and sometimes dangerous business helps the patient. Of course I am referring to the Process vs Outcome argument. The authors indicate at the beginning of the article that they are very well aware of this problem and mention those very few items of screening that may indeed be helpful (if the patient complies with treatment—another unknown). They also state the full impact of what I am trying to say when they conclude at the very end of the article: "It is difficult to escape the moral and perhaps legal implications for health-care providers to at least react to an abnormal finding. Response to this imperative may be facilitated by performance of only those screening procedures whose practical value in affecting ultimate outcome has been fully demonstrated." To my mind then, the very beginning and the very end don't jibe with the main body of the article.

The only conclusions which can be drawn from this study are:

a. for the researcher, don't try to pick out "normal" and "abnormal" retrospectively from patient records, even with an exemplary charting system, and

b. for the clinician, don't do any screening procedures until a beneficial outcome shall have been proved for that procedure.

Stanley Sinclair, MD
Director of Education
Herzl Family Practice Center
Assistant Professor of Family Medicine, McGill University
Montreal, Quebec

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The preceding letter was referred to Drs. Kirkwood and Froom who respond as follows:

We very much appreciated Dr. Sinclair's observations and criticisms of our study and will attempt to respond. To do so we would like to paraphrase his comments into the following:

1. *The significance of results and follow-up is difficult to interpret due to definitions of "abnormality" which involve judgment.*

To reply to specific objections, first, as was noted, all physical findings were scored by the physician as "abnormal or normal." Thus, we accepted his judgment and did not impose ours. Secondly, although many physicians do, in fact, ignore laboratory designations of "abnormal," we question this practice on the grounds that if the results were to prove *clinically* significant, there would be no recorded clinical context to justify the omission. Finally, we can only agree that the evaluation of social and family histories is difficult. We did not include them in order to make a definitive statement about results and follow-up, but rather, since they are often included in periodic "physical examination" protocols, they were included merely to report data which we had not seen reported previously.

We strongly disagree with Dr. Sinclair's statement that all conclusions about abnormalities or follow-up from this study are unwarranted. Surely the results of blood pressure readings, stool guaiacs, vaginal cytologies, hematocrits, ECGs, chest x-rays, etc, are as unambiguous as any in medicine. Furthermore, several of these (blood pressure, pap smear, stool for occult blood) are accepted as being of value using the strict criterion for efficacy that we noted. In spite of that, follow-up was not significantly improved for these latter tests over those which indeed may have been ignored consciously by the physician group we studied.

2. *The main body of the paper, as reported, stands as an endorsement of seeking abnormalities and taking action.*

We regret that Dr. Sinclair reached this conclusion. We felt that from the inception of this study that, although "yearly physicals" are a hoary ritual in primary care, the results from such activities had previously been unreported in the literature. Thus, we reported the results of one such program in its entirety; if you will, warts and all. Also, because reviews published in this *Journal* and *Lancet* had more sharply defined those problems for which screening is probably of value, we were additionally interested in those specific procedures, especially within the context of a family practice.

C. Richard Kirkwood, MD
Anacortes, Washington
Jack Froom, MD
Associate Professor of Family Medicine and Director of Research
Family Medicine Program
University of Rochester-Highland Hospital
Rochester, New York