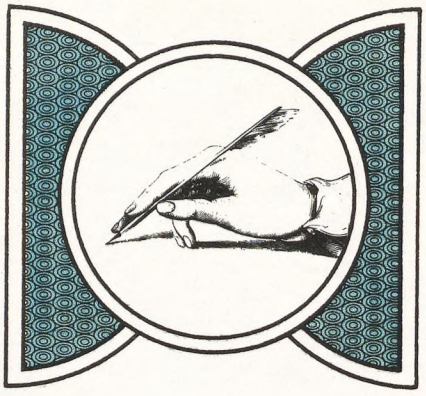
Letters to the Editor



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.

Information on Family Practice Residencies

To the Editor:

In the ten year growth of family medicine, the interest of medical students in the specialty has continued to climb. This is evidenced by not only the number of residency programs and residents, but also the number of applicants to family practice residency positions. Medical students and residents have increasingly requested some format in which basic information about family practice residency programs can be collated. This growing interest also further emphasized the need for program directors to be able to describe their programs in a very succinct manner to potential applicants. These forces were felt by both the American Medical Student Association (AMSA) and the American Academy of Family Physicians (AAFP). As a result of several years' effort on the part of many individuals, this basic information is now available in a publication produced under the co-sponsorship of AMSA and the AAFP.

The Committee on Resident and Student Affairs (CRSA) of the AAFP worked with representatives from AMSA in compiling a student questionnaire on the areas they considered most important in residency programs and family practice. Then, with the appropriate questions collected, the questionnaire was forwarded to all residency programs for completion. The data from the completed programs were compiled and returned to the program directors for substantiation. The booklet was printed and made available through the AMSA offices in June 1979.

The booklet contains an article by myself and Dan Ostergaard, MD, as the former Assistant Director of the Division of Education of the AAFP, concerning how to choose a residency program. Previous approaches have traditionally dealt with controversial aspects of the university vs community settings, program emphasis, etc. This unique introduction uses the philosophy that a prospective resident can learn much about the appropriateness of a training setting

Continued on page 568

Continued from page 566

when applying his/her own standards and ideas about what really is family medicine. Many potential questions are raised and sample questions are given to the students to ask without any ideal listed for answers. However, the questions are related directly to the definition of family practice as adopted by the American Academy of Family Physicians and the American Board of Family Practice.

The material contained in the booklet is comprehensive, objective, educational, and logistical information about each family practice program which responded to the questionnaire. There are only a few programs which did not respond, but their demographic information is nevertheless listed within the booklet. The project will be continued on a yearly basis and is supported in part by a grant from Ciba-Geigy Pharmaceutical Company. Copies of the booklet may be obtained from the American Medical Student Association, 14650 Lee Road, PO Box 131, Chantilly, VA 22021.

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Throat Cultures for Pharyngitis

To the Editor:

I am writing in regard to the article by Dr. Clive Caplan, "A Case Against the Use of the Throat Culture in the Management of Streptococcal Pharyngitis" (*J Fam Pract 8:485, 1979*). My comment would be that he may be right. However, the possibility of being correct, and the actuality of being correct are two different matters. I would certainly agree with his statements regarding the patient with the clinical diagnosis of streptococcal pharyngitis. My scepticism results from his recommendation that patients with the clinical diagnosis of nonstreptococcal pharyngitis do not need a throat culture and also do not need to be treated.

From his own admission, many of these patients do have positive throat cultures. He did not provide evidence to indicate that the group of patients left untreated will not develop elevations of the ASO titer, or in fact will not develop rheumatic fever. Until that information is forthcoming, I will continue to treat patients showing a positive throat culture, knowing full well that many of them do not require treatment.

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To the Editor:

Since I am not inclined to write Letters to the Editor, I am a bit slow in picking up on Clive Caplan's "A Case Against the Use of the Throat Culture in the Management of Streptococcal Pharyngitis"

Continued on page 570

Continued from page 568

in the March 1979 issue (*J Fam Pract 8:485, 1979*).

This should be required reading for all present and future medical practitioners concerned with the management of the patient with a "sore throat."

My practical professors of medicine in medical school (1957) taught that sore throats were streptococcal until proven otherwise, or the patient was well without complications. At that time we were nearing the end of the epidemics of rheumatic fever and glomerulonephritis and the routine throat culture had not become the diagnostic "bible" that dictated whether or not to treat.

Unfortunately, the past 10 to 15 years have caused patients much distress and money in terms of time lost from occupation, visits and revisits to the doctor's office, and costs of the cultures because someone, somewhere preached the gospel that if it were not B hemolytic strep, proved by culture, you should not treat it. It is no wonder that the image of the physician is deteriorated; even the patient can see that his judgment is dictated by peering into a Petri dish.

It is time that we, as physicians, recapture that image that was willed to us by our predecessors, and demonstrate that we have been educated in medicine, that we are capable of exercising practical judgment in both complex and simple matters.

I suggest that there is no better test of diagnostic acumen and practical management of patient problems than that presented by the patient with the "sore throat."

Michael H. Emmick, MD
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To the Editor:

I enjoyed Dr. Caplan's article on the management of streptococcal pharyngitis (*J Fam Pract 8:485, 1979*). In the extremes, streptococcal pharyngitis and viral upper respiratory illnessss are not difficult to distinguish clinically. Unfortunately, he did not discuss specifically the management of those patients whose pharyngitis is not typical of either extreme. This is clearly an area where the throat culture can be of some help.

More importantly, he overlooked a very useful aspect of frequent throat cultures. By reviewing cultures on a daily basis, a clinician has a continuously updated impression of the incidence of streptococcal disease in his/her own practice. During some weeks our cultures will be positive for strep as often as 75 to 80 percent, while in other weeks it will be the opposite. This does not necessarily correlate in our experience with the seasons, nor would the etiology of these local epidemics be obvious clinically. Clearly we are better able to make judgments in borderline cases with knowledge of our recent culture results.

I believe another reason to get throat cultures is to keep yourself "honest." Upon entering private practice, without the pervasive atmosphere of critical evaluation, many physicians find it is easier to treat all upper respiratory tract illnesses with antibiotics. Routine use of the cultures provides an ongoing check on one aspect of our diagnostic acumen. It is probably worth it for that alone.

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Continued on page 572

Continued from page 570

To the Editor:

The article by Caplan, "A Case Against the Use of the Throat Culture in the Management of Streptococcal Pharyngitis" (*J Fam Pract 8:485, 1979*) is somewhat misleading on several issues. Although we agree with the philosophy to improve medical practice by reducing or ending the use of unnecessary procedures, we agree with Bisno[1] that "After all these years the simple sore throat remains a surprisingly complex problem."

Caplan quotes Mondzac's[2] data to attack the validity of office throat cultures and also refers to Rosenstein[3] and Battle[4] to further support this conclusion. The latter two authors, in fact, took issue with Mondzac and their data actually support the validity of the office culture. Rosenstein reported that when moderate growth was present, office culture's agreement with the health department laboratory was 90.3 percent. Battle found that only four percent of all positive cultures in the reference laboratory were found to be negative in the office and most of these were in the 1+ and 2+ category. Caplan states that even under the best of conditions perhaps 20 percent of throat cultures from patients with genuine streptococcal pharyngitis may be negative. This is not supported, however, by the above authors or by others. Kaplan[5] showed that a patient harboring Group A streptococcus will have a negative culture ten percent of the time.

He further elaborates that "the degree of unnecessary treatment will be less than if the culture is relied upon, for more than half of positive cultures in acute pharyngitis have already been shown not to signify a streptococcal infection." But what of the missed cases? In a careful and detailed study, Honikman[6] evaluated a total of 6,093 respiratory and febrile illnesses in children using multiple cultures and also titer determinations. In order to have treated 88.1 percent of those clinical infections which resulted in an ASO titer rise, one would have had to treat all children with pure or predominant sore throat and fever of any degree ($\geq$ 37.3) and all children with any illness and fever $\geq$ 38.3. Without throat cultures this would be 29.5 percent of 6,093, or 1,798 of these illnesses. If one treated only culture positive children, one would treat 27.3 percent of these 1,798, or only eight percent of the total, compared with 29.5 percent by relying on symptoms alone. To treat indiscriminately with antibiotics carries a real risk of an increased number of allergic reactions and to treat fewer children without a culture would appear to leave an unacceptably high percentage at risk for acute rheumatic fever. We grant that streptococcal pharyngitis can be detected clinically, more reliably in adults than in children, but if the goal is to prevent rheumatic fever one would do well to heed the fact that acute rheumatic fever appears most commonly between 5 and 15 years of age.

Tompkins[7] cost effectiveness analysis which suggested treating all patients with suspected streptococcal disease refers only to the epidemic situation or to those cases in which the positive throat culture yield is at least 20 percent. When the culture positive yield is 5 to 20 percent, he recommends treatment of only culture positive individuals. Moreover, Honikman[6] and others point out that a rise in the ASO titer

Continued on page 576

Continued from page 572

can occur in a high percentage of infections that are not classic for streptococcal pharyngitis; and that a high percentage of clinically "classic" streptococcal pharyngitis cases will be culture negative and not followed by a rise in ASO titers.

Although the management of pharyngitis might be simpler if one could treat without a culture, it is our conclusion that the throat culture (or a Gram stain in experienced hands[8]) remains necessary. The throat culture with all its shortcomings and surrounding controversy should definitely not be abandoned.

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References

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Training in Office Orthopedics

To the Editor:

I read with interest the comments by Dr. John P. Geyman, in his editorial, "Toward the Definition of Orthopedic Care in Family Practice" (*J Fam Pract 8:699, 1979*).

For some years, I have been connected with the work of Dr. James Cyriax, of London, England, who has developed a method of examination and treatment of nonsurgical problems of the musculoskeletal system, which he calls Orthopedic Medicine. He estimates in his lectures that 20 percent of all patients who come to a family physician's office have problems of the musculoskeletal system, and indeed, this is borne out in my own practice.

I would commend his lectures, which are given twice a year in Rochester, New York, at the School of Medicine, Department of Orthopedics. The last lecture series was held September 20-24, 1979. Additional information may be obtained by writing to the Postgraduate Division of Continuing Education, University of Rochester.

One area of great neglect, in all medical schools with the exception of the University of Rochester, is the teaching of a method of examination of the musculoskeletal system using the concepts of applied anatomy and dermatomes. Dr. Cyriax's system is clear, precise, logical, and reproducible. I would strongly recommend to any of your readers who are interested in expanding their knowledge of the management of nonsurgical problems of the musculoskeletal system that they consider attending these lectures.

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