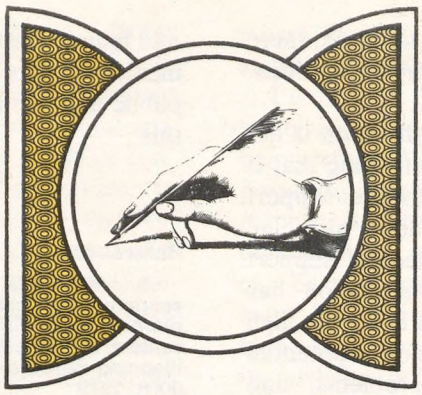
Letters to the Editor



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.

Pediatric Training in Family Practice Residencies

To the Editor:

In evaluating pediatric training in family medicine residency programs, Rabinowitz and Hervada[1] published a formula for calculating "pediatric equivalent months," which was also mentioned in the editorial[2] in the same issue of *The Journal of Family Practice*. This formula provides a useful measure for determining "specialty equivalents" for all ambulatory specialty training offered in family practice centers (FPC). Use of the formula, however, necessitates use of a reciprocal formula for reducing the time spent by residents in block rotations if you intend to add block rotation time to family practice center equivalent time to determine specialty training time totals. Failure to make this reduction would create the erroneous impression that it is possible to have more than twelve months of training in one year.

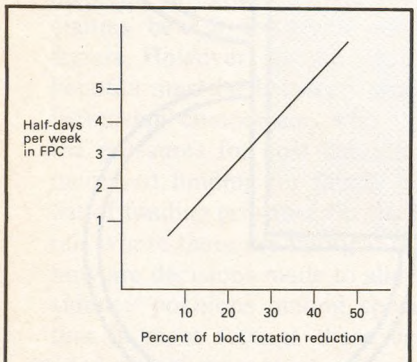


Figure 1. Relationship of time spent in family practice center (FPC) to reduction of time spent on block rotations

I have shown the simple linear relationship for this reduction in Figure 1. Note that a resident who spends 1.6 months in a year (Rabinowitz and Hervada's Year I average) in the family practice center (1.3 half-days/year) will spend 13 percent less than a month on each calendar month block rotation that year. As the days per week in the family practice center increase during the three years of training, this reciprocal adjustment increases in a linear fashion. To illustrate the result of not making this reduction when calculating "pediatric equivalents," look at the 5.6 months of block rotation in pediatric training in Rabinowitz and Hervada's article. If one assumes (the paper does not say) that residents took two thirds of the 5.6 months of pediatric block training in Year I and one third in Year II, then:

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Year I (1.3 half-days/week in FPC)
$5.6 \times 2/3 = 3.7 \times 0.13$ (Figure 1) $= 0.5$
3.7 (uncorrected) − 0.5 correction
$= 3.2$ months
Year II (3.0 half-days/week in FPC)
$5.6 \times 1/3 = 1.9 \times 0.30 = 0.6$
1.9 (uncorrected) − 0.6 correction
$= 1.3$ months
3.2 months plus 1.3 months = 4.5 months (corrected) block time

Residents thus spend 4.5, not 5.6, months in block pediatric training if adjustment is made for time spent in the family practice center. Since I feel the "specialty equivalent" calculation is a useful one that will and should be used, I draw your attention to the necessary reciprocal adjustment when total training time (FPC plus block rotation) is calculated. Obviously, this reduction is necessary only for block rotational programs.

David M. Holden, MD
Director
Wesley Medical Center Family Practice Residency Program
Professor of Family Medicine & Pediatrics
University of Kansas School of Medicine-Wichita
Wichita, Kansas

References

1. Rabinowitz HK, Hervada AR: Pediatric training in family medicine residency programs. J Fam Pract 11:575, 1980
2. Geyman, JP: Pediatric training in family practice residencies. J Fam Pract 11:531, 1980

The preceding letter was forwarded to Dr. Rabinowitz, who responds as follows:

I thank Dr. Holden for his interest and perceptive comments. In our study, we became aware that a number of family medicine residency programs have full-time block rotations in the family practice center ("x" number of months per year), while others utilize longitudinal training in the family practice center ("x" number of half-days per week). In addition, some residency programs have pediatric block rotations where family practice residents spend longitudinal time (eg, one half-day per week) in the family practice center, while other programs have pediatric block rotations where family practice residents do not spend longitudinal time in the family practice center (because of distance or other factors). Most programs have a combination of the above; however, because our questionnaire did not anticipate these results, we were unable to accurately separate out these variables. Dr. Holden's reciprocal formula, while accurate, applies only to those pediatric block rotations where family practice residents spend longitudinal time in the family practice center. In addition, Dr. Holden's calculations assume that all family practice residents spend only longitudinal time in the family practice center (eg, he assumes that the 1.6 months the first year resident spends in the family practice center is calculated entirely on a longitudinal basis, but in fact for some programs a portion of this time occurs on family practice center block rotations). Dr. Holden's calculations, therefore, would reduce somewhat our total training time, but less than the 1.1 months that he suggests, since it applies only to a portion (unknown) of the programs.

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Using the number of months of training in describing the pediatric component of family practice residency training programs is a valuable first estimate. The effect of variables in addition to Dr. Holden's reciprocal formula, such as vacation time and night call while on pediatric and family practice rotations (which could either increase or decrease total training time), were not controlled in our study. Nevertheless, even when these minor effects are controlled in order to increase precision, our conclusions would not change.

Howard K. Rabinowitz, MD
Assistant Professor of
Family Medicine
Clinical Instructor in Pediatrics
Jefferson Medical College
Philadelphia, Pennsylvania

Management of Hyperlipoproteinemias

To the Editor:

I feel compelled to comment on the article "The Hyperlipoproteinemias" by Dr. Thomas F. Whayne, Jr. (*J Fam Pract* 11:789, 1980). I feel there are a number of deficiencies in the author's management of hyperlipoproteinemias that ought to be recognized, particularly since this article appears in a major journal of family practice.

Nowhere is it mentioned that reduction to ideal body weight would be beneficial in the treatment of hyperlipoproteinemias, whereas this is a mainstay of management in Types IIb, III, IV, and V. In addition, the role of complex carbohydrates as opposed to simple carbohydrates is not mentioned. L'Heureux (personal communication of a paper presented to The North American Primary Care Research Group, 1979) has determined that total cholesterol levels in lacto-ovo-vegetarians are significantly lower than their nonvegetarian siblings, and Sacks and his colleagues[1] have noted significantly lower cholesterol, low density lipoprotein (LDL) and very low density lipoprotein (VLDL) levels, and slightly lower high density lipoprotein (HDL) and triglyceride levels in vegetarians as opposed to nonvegetarian controls. In addition, there was one person with an intermediate density lipoprotein (IDL) type of hyperlipoproteinemia who was phenotypically normal while on a vegetarian diet and abnormal while eating a regular diet.

My own clinical experience has been that familial Type IV hyperlipoproteinemia can be successfully managed by a combination of weight reduction and a complex carbohydrate diet. I feel that the article in question pays far too much attention to drug treatment and far too little attention to lifestyle modification. In addition, there is only brief mention made of controlling the other associated cardiovascular risk factors, such as smoking and hypertension.

I have also begun to question the usefulness of using the Fredrickson classification in the management of hyperlipoproteinemia, since dietary management may be remarkably similar for many of the different types of hyperlipoproteinemias, and drug thereapy is more aptly chosen on the basis of whether the drug has its major effect on the triglycerides fraction or the choles-

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terol fraction. Although I have no data to back me up on this, I feel that the use of lipoprotein electrophoresis or ultracentrifugation as a diagnostic screening procedure is probably not cost effective, and that measurement of total cholesterol, triglycerides, and perhaps HDL cholesterol and examination of blood supernatant provide sufficient information for diagnosis and management of most of the hyperlipoproteinemias seen in a family practice.

Robert M. Bernstein, MD, PhD
Ottawa, Ontario

Reference

1. Sacks FM, Castelli WP, Donner A, et al: Lipids and lipoproteins in vegetarians and controls. N Engl J Med 292:1148, 1975

The preceding letter was forwarded to Dr. Whayne, who responds as follows:

I concur with Dr. Bernstein's point that familial Type IV hyperlipoproteinemia can be managed by weight reduction and complex carbohydrate diet and simple carbohydrate restriction. In fact, my paper included a specific statement regarding diet as the cornerstone of management. My article was intended as an overview, and both diet and drug treatment were discussed. Concerning the treatment of hyperlipoproteinemia, it is specifically emphasized that "if the clinician accepts cholesterol reduction in patients as worthwhile, then the following describes a rational therapeutic approach." I then proceeded to outline diet and drug management, but always with the proviso that the individual clinician must look at the prevention and regression data and convince himself that there is benefit in lipid reduction. I believe that the evidence points to the fact that there is benefit, but I always carefully qualify that it is not rigidly proven and that each responsible clinician must look at the data himself.

Dr. Bernstein makes a comment that there is only brief mention of controlling other associated cardiovascular risk factors, such as smoking and hypertension; this is a trivial and inappropriate observation. The purpose of my article was to discuss the hyperlipoproteinemias and not the management of multiple risk factors. I, of course, concur with him in the importance of this and emphasize this very strongly in my busy cardiovascular practice.

Dr. Bernstein also questions the usefulness of using the Fredrickson classification for the management of hyperlipoproteinemias. As stated in my paper, I believe that the typing system is only a language for communication. It is appropriate to continue to use this system, which is now understood by most clinicians and represents a convenient way to communicate. The key point is to understand that it does not imply underlying mechanisms or genetics. It appears to me rather ridiculous that some investigators in the field are now trying to tear down this system and substitute other terminology that does not say any-

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thing different but makes for further controversy, and does not contribute new knowledge or a significant new classification system.

Dr. Bernstein comments on the lack of data to back him up but states that he feels the use of lipoprotein electrophoresis or ultracentrifugation as a diagnostic screening procedure is probably not cost effective. I state specifically regarding electrophoresis on page 791 that it is of no value in the assessment of the hyperlipoproteinwith the ultracentrifuge. I object strongly to laboratories that use electrophoresis alone and charge a high fee for a test that contributes nothing. I do concur that in this situation the measurement of total cholesterol and triglycerides is very valuable, coupled with the observation of the serum overnight as outlined on pages 792 and 793 under simple office procedures. However, to specifically diagnose Types IIb, III, and IV precisely, the ultracentrifuge is essential, unless one has available a specific research methodology involving immunoprecipitation techniques. Using the simple office procedure approach, it is possible to estimate this sufficiently to make a clinical trial of diet and specific medication. Especially in the case of Type III, specific typing is essential, most specifically in regard to benefit from clofibrate as the drug of choice. At the Lexington Clinic, we charge $25.00 for a complete lipoprotein ultracentrifuge analysis by the Beckman Airfuge system, which includes the complete analysis plus the total cholesterol and triglycerides. The methodology is much more precise than precipitating the VLDL and LDL to determine the HDL cholesterol, followed by extrapolation by inaccurate formulas. Also, the ultracentrifuge will diagnose Type III disease. Obviously, it is possible to offer this service at a very reasonable price, and I suspect at a level charged by some laboratories for HDL cholesterol, total cholesterol, and triglycerides alone.

Thomas F. Whayne, Jr., MD
Cardiology Section
Lexington Clinic
Lexington, Kentucky