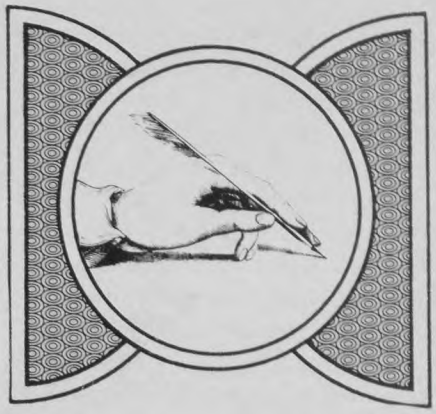
Letters to the Editor



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.

Child Abuse and Incest

To the Editor:

I would like to take issue with one of the final comments Dr. Janet Realini made in the Family Practice Grand Rounds of April 1984. "When we see a teenager who runs away, or acts out, or is isolated, we should 'think dirty' and wonder if incest is involved."[1]

As a clinician who has seen several incest survivors, I have recognized that one of the chief problems is a very low self-esteem and a feeling that they are indeed "dirty" and not worthy of love, care, or attention. I believe they are also sensitive to attitudinal cues, spoken or unspoken, that a health professional might put forth. If health professionals feel that incest is indeed dirty, the care that they will provide for that incest survivor will be suboptimal. It is not what a survivor needs to hear.

The physician needs to emphasize that the responsibility for the incest does not rest with the child. The survivor's self-esteem and sense of worth must be promoted to avoid more serious problems in adult life. Indeed, the role of supporting the incest survivor may preclude the physician from being an effective counselor for the whole family.

Abuse of children, physical or sexual, must never be tolerated. A teenager who runs away, acts out, or is isolated should be able to build rapport with her personal physician in confidence. If a child is also seeing a social worker, counselor, or psychologist, there should be open communication among all caring for the child. It may be only then that a physician will be entrusted with the history of abuse.

I would hope that Dr. Realini would be willing to change her "think dirty" to "think abuse" and give the survivor a chance.

Elizabeth A. Burns, MD
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Reference

1. Realini JP, Ortiz E, Turnbull JM, Couchman GR: Family dynamics: A case of incest. J Fam Pract 1984; 18:529-541

The preceding letter was referred to Dr. Realini and Dr. Ortiz, who respond as follows:

We appreciate Dr. Burn's comments and concerns. We agree entirely with her that a sympathetic and supportive attitude on the part

of the health professional is essential in caring for a victim of incest or other abuse.

The expression "think dirty" was intended to encourage a high index of suspicion of abuse and incest when caring for children and adolescents—and adults as well. Without a high sensitivity to subtle clues and vague clinical suspicions, the physician or other health professional may miss the diagnosis of incest.

The word "dirty" describes feelings that most people in our society—including many health professionals—have about incest. Health care professionals must be able to recognize their own negative feelings about this traditionally taboo subject in order to deal with them appropriately. We agree with Dr. Burns that such feelings should not be allowed to interfere with treatment of incest victims and incestuous families.

We appreciate Dr. Burns' pointing out this expression; its use was not intended to foster negative attitudes toward victims of sexual abuse.

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Alphabetized ICHPPC-2 Condensed List

To the Editor:

Use of *International Classification of Health Problems in Primary Care*, (ICHPPC)[1] gradually, but steadily increased in primary care practices throughout the world. Continued compatibility with the *International Classification of Disease, Revision 9* (ICD-9)[2] through the development of ICHPPC-2 guarantees an ongoing link with data bases of other sites (eg, hospitals) and other specialties. More recently the release of "*ICHPPC-2-Defined*"[3] begins the important process of establishing widely acceptable criteria for the use of a diagnostic label.

ICHPPC-2 includes a listing of rubrics in tabular form as well as an appendix of condensed titles for machine processing. In addition, a detailed index is included for access to the appropriate rubrics. Each of these lists has specific uses. We found, however, that none of them adequately served as a quick reference for the busy practitioner who is familiar with the full code.

We have found it helpful to use a condensed one-page list* of all the ICHPPC-2 rubrics alphabetized within each category (class) while keeping the original titles and their codes. Once the physician decides on a diagnosis or problem name, he can use this chart as an aid to quick, accurate, and reproducible (preprinted) coding. We have found this to be a useful aid for both residents and faculty, and it is taped to the desk or wall by each dictation machine.

This list is not meant to replace the whole ICHPPC-2 book but to serve only as an additional tool for easy coding within the framework of ICHPPC. In this format it is par-

*Available on request by writing to the authors at the Department of Family Medicine, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425.

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ticularly helpful for the many busy clinicians who wish to code problems themselves during patient care hours, enabling them to describe (analyze) the broad content of health care rendered to patients in their family and general practices.

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References

1. International Classification of Health Problems in Primary Care (ICHPPC). Report of the Classification Committee of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians. Chicago, American Hospital Association, 1975
2. International Classification of Diseases, Revision 9. Geneva, World Health Organization, 1977
3. ICHPPC-2 Defined. (International Classification of Health Problems in Primary Care, Third Edition). Prepared by the Classification Committee of WONCA (World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians) in collaboration with the World Health Organization. Oxford, Oxford University Press, 1983

Estrogen Therapy

To the Editor:

I enjoyed and agree with the article by Drs. Hahn, Nachtigall, and Davies *(Hahn RG, Nachtigall RD, Davies TC: Compliance difficulties with progestin-supplemented estrogen replacement therapy. J Fam Pract 1984; 18:411-414)*. However, I disagree with the frequency of progesterone administration. I see absolutely no reason why a woman should endure "the curse" on a monthly basis as occurs premenopausally. Why not with each prescription for 100 estrogen tablets give a prescription for 10 progesterone tablets to take with the last 10 days of the estrogen, so that if she has endometrial hyperplasia she will have a shedding on a three-month cycle?

Richard G. Hopkins, MD
Columbus, North Carolina

The preceding letter was referred to Dr. Hahn, who replies as follows:

In response to Dr. Hopkins' letter, we agree with him about subjecting postmenopausal women to the monthly "curse"; however, as previously described by Studd et al,[1] in order to reduce the incidence of endometrial hyperplasia to zero, supplementation with progestin is necessary for 13 days out of the cycle given the presently available pharmacologic agents.

Whether less frequent administration still decreases the risk of endometrial cancer is not known at present.

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Reference

1. Studd JWW, Thom MH, Paterson MEL, Wade-Evans T. The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens. In Pasetto N, Paoletti R, Ambrus JL (eds): The Menopause and Postmenopause. Lancaster, Pa, MTP Press, 1980, pp 127-139