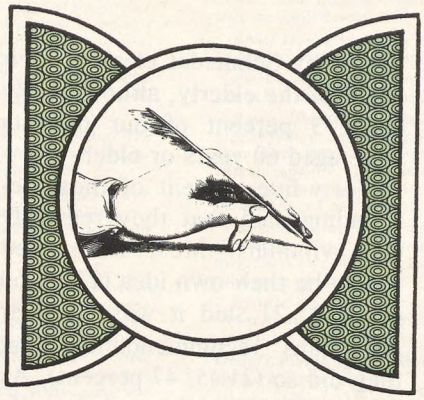
Letters to the Editor

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.



Disability Assessment

To the Editor:

We agree with Dr. Battista *(Battista ME: Assessment and the family physician. J Fam Pract 1983; 16:835-836)* on the importance of physician competence in the evaluation of patient impairment for purposes of "disability assessment." We further agree with his view that this competence should be addressed in residency training.

At the University of Arizona, residents from training programs in family medicine, occupational medicine, and general preventive medicine have been able to participate in these patient evaluations on a regular basis, both within the Family Practice Office and our separate clinical facility for occupational health, via a special vocational rehabilitation contract with the Arizona Department of Economic Security. In addition, full-time short rotations in "disability assessment" exist at one of our Phoenix training sites, the Southwest Disability Evaluation Center. Such a rotation is presently a requirement for all residents in occupational medicine and is available to interested family medicine residents during elective time.

The University of Arizona has also been involved in various training activities in this area on a somewhat larger scale, including the development of a specific educational module[1] on the subject. Training for physicians and teachers of family medicine in the evaluation of impairment was also provided within core workshops as part of the 1983 National Conference of Occupational and Environmental Health Education in Family Medicine, co-sponsored by STFM and AAFP.

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1. Rea JL, Edwards WV, Cordes DH: Physician evaluation of impairment, project module. Health Resources Administration Contract No. 232-81-0047. Government Printing Office, August 1983

Diet and Constipation

To the Editor:

I am writing with regard to the Grand Rounds discussion in the May issue of *The Journal of Family Practice (Meza JP, Peggs JF, O'Brien JM: Constipation in the elderly patient. J Fam Pract 1984; 18:695-703).* Many possible causes of constipation were listed; however, no one mentioned the possibility that an elderly person may be selecting a diet abnormally low in fresh fruit and vegetables and therefore abnormally low in fiber. The American Dental Association estimates that 50 percent of 65-year-old and 66 percent of 75-year-old people have lost all their teeth; 80 percent of these fail to replace them or replace them with dentures that do not fit properly.[1] People who have trouble chewing foods will select foods that require little chewing.[1] Often the foods that are eliminated include fruit and vegetables. An important source of fiber is reduced, and problems of constipation may be precipitated or exacerbated.

Constipation is a health problem routinely treated by physicians. However, it may also be a symptom of a more significant problem, malnutrition. Malnutrition can result from a diet inadequate in foods that are high in fiber: fresh fruits, vegetables, and whole grain products. These foods are also important sources of vitamins and minerals. In fact, data based on the Ten-State Nutrition Survey (1968-1970)[2] and the first Health and Nutrition Examination Survey (HANES, 1971-1974)[2] indicate that 50 percent of persons aged over 60 years consumed less than two thirds of the recommended dietary allowance (RDA) for vitamin A, and 20 to 30 percent consumed less than two thirds of the RDA for vitamin C. The primary food sources of vitamins A and C are fruits and vegetables. Constipated clients with metabolic problems and long medications lists are at even great risk of developing malnutrition.[3]

The physician who chooses to treat constipation by recommending that the patient add All-Bran to recipes or meals is in effect using All-Bran as a laxative. Such treatment will get the bowels moving

again; it does not, however, correct the poor eating habits that lead to constipation in the first place.

So, what is the alternative? Treatment of constipation in the older patient should include (1) disimpaction, if necessary, (2) fluid intake of at least 1,500 mL/24 hr, (3) an increase in physical activity, and (4) patient education regarding normal bowel function (including why normal bowel function is dependent on adequate fiber in the diet) as well as a basic eating plan that provides adequate fiber and other nutrients. Any dietary advice should emphasize a balanced diet containing sufficient amounts of fresh fruit, vegetables, and whole-grain products.

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1. Krause MV, Mahan LK: Food, Nutrition and Diet Therapy (ed 7). Philadelphia, WB Saunders, 1984
2. Guthrie HA: Introductory Nutrition (ed 5). St. Louis, CV Mosby, 1983, p 518

Vitamin and Mineral Usage in Adult Family Practice Patients

To the Editor:

We recently surveyed 100 patients attending our family practice office regarding their use of vitamins, minerals, and "health foods." By means of a questionnaire we asked our adult patients about their habits with respect to the regular ingestion of vitamins, minerals, or health foods. Patients who admitted taking any of these substances were additionally asked what kind and how they happened to start.

The prevalence of vitamin taking in our practice is similar to that reported by Schneider et al[1] in their study of the elderly, although only about 3 percent of our patients were aged 60 years or older.

Forty-five percent of those responding said that they regularly take vitamins. Most maintained this to be their own idea (27/45, 60 percent); 21 said it was on their physicians' recommendations that they did so (21/45, 47 percent). As their response totals more than 45, it seems likely that several of our patients quite rightfully appreciated an ambivalence in their physicians' recommendations, or that the physicians' recommendations were actually in response to direct questioning on the part of the patient and not solicited.

Although 8 (8/45, 18 percent) said they were taking vitamins on the advice of their families, only two patients (5 percent) admitted their vitamin ingestion was on the basis of advice gleaned from radio, television, or magazines.

Thirteen patients said they were taking minerals, but the number doing so is actually higher because all but one patient whose vitamin preparations included mineral supplements did not list minerals in response to the question about mineral ingestion. Iron (3 persons), zinc and selenium (2 each), and manganese and potassium (1 each) were mentioned as minerals they were taking by nine patients.

Seven patients said they were taking a daily vitamin with mineral combination. Iron, though frequently included in the vitamin preparation named by the patient, was not specifically mentioned as a mineral by many.

"Multivitamins" named without brand were the vitamins most frequently listed; eight brand names were each mentioned once. Single vitamins included vitamin C (14 persons), E (6 persons), B (5 persons), and thiamine (1 person).

None of the patients surveyed admitted to taking such vitamins as A, D, and pyridoxine, which are apt to be toxic in excess quantities. Whether the 45 percent taking vitamins indeed need to do so was not part of this survey. Only approximately 3 percent or fewer of our patients were aged over 60 years (uncertainty is because not all of our respondents chose to reveal their ages), the age group that may be especially prone to vitamin deficiencies.[2,3] Three of our patients were pregnant; vitamin supplementation is presently an accepted prescription in all pregnancies, although the need, at least in this country for every woman, has not been rigorously proven.

John Fried contends in his book *Vitamin Politics* that Americans squander nearly $3 billion a year on vitamins that are either unnecessary or unhealthful. Even if his figures are exaggerated, it seems appropriate that family physicians pay attention to substances which approximately one half their patients are taking.

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2. Bazzare TL: Nutrition requirements of the elderly. In McCue JD (ed) Medical Care of the Elderly. Lexington, Mass, The Collamore Press, pp 336, 341
3. Bowman BB, Rosenberg IH: Assessment of the nutritional status of the elderly: A practical approach. Am J Clin Nutr 1983; 35:1142-1151