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.

HYPERCHOLESTEROLEMIA

To the Editor:

Diane J. Madlon-Kay demonstrated that the physicians she studied were unaggressive about diagnosis and treatment of hypercholesterolemia (*Family physician recognition and treatment of severe hypercholesterolemia. J Fam Pract 1987; 24:54–56*). Several points about the article are noteworthy. Cholesterol levels were determined by "automated chemical screening" and interpreted by the Lipid Research Clinics' (LRC) standards.[1] Method of performance of cholesterol is vitally important to interpretation: an LRC value of 260 mg/dL is equivalent to a Technicon SMAC value of 295 mg/dL and a DuPont *aca* value of 315 mg/dL.[2] The mean cholesterol level in Dr. Madlon-Kay's study was 293 mg/dL. A DuPont *aca* value of 290 mg/dL is the equivalent of an LRC value of 240 mg/dL, recommended treatment for which is that for the general population.

Dr. Madlon-Kay's data are consistent with discordant methodologies for determining and interpreting the cholesterol values. The LRC defined high-risk blood cholesterol levels as those above the 90th percentile, which, by their method, was 260 mg/dL.[1] Directly applying the LRC cholesterol value of 260 mg/dL to the values received from her laboratory, Dr. Madlon-Kay found about 25 percent of her population (rather than the anticipated 10 percent) to have "severe" hypercholesterolemia.

Also noteworthy is that the mean age of patients was 56 years. Especially if other risk factors for coronary disease are absent, the benefit of treating this group of patients would seem to be proportionately less than for younger age groups.

For younger adults whose hypercholesterolemia is not controlled with diet, some well-informed physicians may still advocate caution with drug therapy. The National Institutes of Health consensus conference report specifically states that "we still do not have direct evidence for the safety of any cholesterol-lowering drugs when given over decades; therefore, drug treatment should be undertaken cautiously and its desirability should be periodically reevaluated."[1] Availability of low-cost, well-tolerated drug therapy is another consideration when treating asymptomatic people who are at risk for, but do not have, a disease. Additionally, conclusive evidence that overall mortality is reduced by drug therapy for hypercholesterolemia is still lacking.[3] Considering low-risk therapeutic alternatives, recent evidence suggests that cholesterol levels can be modified by behavior counseling to reduce type A behavior and stress.[4]

Asymptomatic people labeled with "hypercholesterolemia" might be expected to exhibit increased "sick" behavior, parallel to the iatrogenically induced symptomatology observed after the diagnosis of hypertension.[5] As family physicians treating patients and not diseases, are we comfortable that we are preventing more malaise than we are creating with our "new" diagnosis?

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References

1. Consensus conference: Lowering blood cholesterol to prevent heart disease. JAMA 1985; 253:2080–2086
2. Blank DW, Hoeg JM, Kroll MH, Ruddel ME: The method of determination must be considered in interpreting blood cholesterol levels. JAMA 1986; 256:2867–2870
3. Olson RE: Mass intervention vs screening and selective intervention for the prevention of coronary heart disease (commentary). JAMA 1986; 255:2204–2207
4. Gill JJ, Price VA, Friedman M, et al: Reduction in type A behavior in healthy middle-aged American military officers. Am Heart J 1985; 110:503–514
5. Burke W, Motulsky AG: Hypertension: Some unanswered questions. JAMA 1985; 253:2260–2261

The preceding letter was referred to Dr. Madlon-Kay, who responds as follows:

Dr. Fox raises several important issues, of which the first is crucial to the proper interpretation of my study. Dr. Fox correctly emphasizes the importance of the laboratory method of cholesterol determination. The Eisenhower Army Medical Center laboratory uses the Technicon SMAC method for cholesterol testing as part of an automated chemical screening panel. A recent article reported that cholesterol levels determined by this method were approximately 8 percent higher than the method used by the Lipid Research Clinic (LRC).[1] However, when the Eisenhower laboratory tested its own machine against LRC standards, a positive bias of only 3.5 percent was found. A review of my data shows that 13 percent of the patients in the study who had been diagnosed with severe hypercholesterolemia should therefore actually belong in the moderate hypercholesterolemia category. However, the NIH consensus conference recommendations for treatment of these two groups is identical—diet and, if necessary, drug therapy.[2]

The rest of Dr. Fox's comments are criticisms of the NIH recommendations. The issue of mass cholesterol

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screening and treatment is a relatively new one and has inevitably generated some controversy. Many of the arguments against the NIH recommendations have been summarized elsewhere.[3] It is certainly possible that the physicians in my study recognized and treated so few of the patients with severe hypercholesterolemia because they had similar reservations about the NIH recommendations. My data suggest, however, that the major reason for the poor performance was much simpler: physicians reviewing automated screening panels with 20 test results primarily noticed the cholesterol result when it was greater than 305 mg/dL and therefore marked as abnormal.

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References

1. Blank DW, Hoeg JM, Kroll MH, Ruddel ME: The method of determination must be considered in interpreting blood cholesterol levels. JAMA 1986; 256:2867–2870
2. Consensus conference: Lowering blood cholesterol to prevent heart disease. JAMA 1985; 253:2080–2086
3. Olson RE: Mass intervention vs screening and selective intervention for the prevention of coronary heart disease. JAMA 1986; 255:2204–2207

QUALITY OF CARE AND COST CONTAINMENT

To the Editor:

Disquiet over rising medical costs will continue to be a leading concern among health care providers, patients, medical educators, third-party payers, employers, and government officials as we enter the late 1980s. The guest editorial, "Ethical Gatekeeping: The Ongoing Debate" by Howard Brody (*J Fam Pract 1986; 23:539–540*) and the accompanying essay "A Program for Family Medicine in a Era of Cost Constraints" by Stephen Smith (*J Fam Pract 1986; 23:588–592*) in the December 1986 issue of *The Journal of Family Practice,* each addresses with considerable skill the leading issues of cost containment from both a global ethical perspective and a family medicine education perspective.

As one involved in urban, inner-city family medicine, I have been cognizant of monetary issues, for the poor in this country have always faced cost constraints in the area of medical care. That such a concern is becoming so widespread, involving all sectors of our society, can perhaps be viewed as movement toward social equality!

Nonetheless, concern for costs need not always be viewed from a negative perspective, as it can actually enhance quality. This concept, which relates costs to quality, was mentioned briefly by Dr. Brody and needs to be expanded. As Donabedian has written, the "principle of parsimony" traditionally has been the hallmark of virtuosity in clinical performance.[1] His basic tenet is that quality costs money, but that redundant care, even when it is harmless, indicates carelessness, poor judgment, or ignorance with a resultant misuse of scarce resources that could have been used for other social programs. Further, often unnecessary care is not harmless but rather leads to added risks and side effects, thereby reducing overall quality; hence, the excessive and injudicious use of diagnostic and therapeutic modalities can lower the quality of care both on an individual basis when risks outweigh benefits and on a societal basis through the improper use of resources.

For this reason and because of those discussed by Drs. Brody and Smith, family physicians should be at the forefront in both practicing and teaching parsimonious quality-based care.

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Reference

1. Donabedian A: The Definition of Quality and Approaches to its Assessment. Ann Arbor, Mich, Health Administration Press, 1980, vol 1, pp 1–30

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PREVENTION OF TRAVELER ILLNESS

To the Editor:

Drs. Pust, Peate, and Cordes have written a comprehensive article on the subject of travel medicine (*Pust RE, Peate WF, Cordes DH: Comprehensive care of travelers. J Fam Pract 1986; 23:572–579*). It will be very helpful to the family physician who takes the time and interest to advise travelers. The following additional points are worth emphasizing.

Japanese encephalitis is a serious health threat to certain travelers who will spend considerable time (longer than three weeks) during June to October in rural areas of northern tropical Asia (India, Bangladesh, Korea, China, Nepal, Burma, Viet Nam, Japan, Thailand, and eastern areas of the USSR). Outbreaks also occur in endemic areas of southern India, Indonesia, Malaysia, Singapore, southern Thailand, and Sri Lanka). Mortality can approach 20 percent of those infected with this virus. Although the Japanese encephalitis vaccine is not generally available in the United States, the Centers for Disease Control has arranged a network of physicians who can administer the vaccine. Contact Dr. Jack Poland, PO Box 2087, Fort Collins, CO 80522-2087 (303-221-3144) for further information.

Prevention of other environmentally relevant conditions, such as motion sickness and high altitude sickness, were not mentioned. Scolopamine patch (Transderm-scop) for the former and acetazolamide (Diamox) for the latter are both well-proven remedies that should be given to appropriate travelers.

Dr. Dupont's recent article in *The Journal of the American Medical Association* (*1986; 255:757*) demonstrated the superiority of loperamide (Imodium) over bismuth subsalicylate (Pepto-Bismol) for treatment of acute mild traveler's diarrhea. Since this article came out after theirs was submitted, it is understandable that the information was not included.

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The preceding letter was referred to Dr. Pust, who responds as follows:

We agree. The increased concern and US distribution system for Japanese encephalitis vaccine both arose after our article's text-revisions deadline. Space limitations dictated deletion of noninfectious environmental problems. We list Dr. Dupont's article on page 578.

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USE OF FAMILY CHARTS

To the Editor:

I would like to comment on the recent article, "Promotion of Family Enrollment in an Urban Family Practice Residency Program" by Gropper, Sadovsky, Fraser, and Weiner (*J Fam Pract 1986; 24:57–60*).

The article does not make it clear, but if the program at the Department of Family Practice at Downstate Medical Center in Brooklyn is typical, I doubt very much that families are filed by family. That is, when the patient comes to the health facility, the individual chart is pulled and that patient is seen as an individual rather than as a family member.

It has been my experience, both in private practice and in university programs, that one loses many opportunities to behave as a family physician if he has only the individual's chart before him in the clinical encounter. This is true even though there may be some type of family history in the chart.

What is needed is the actual chart of every individual in the family that is using the facility. Parents are then asked pertinent questions by the family physician, and what is even more important, the dialogue begins involving the health status of other members of the family.

Family practice programs must file by family. Unless each chart is in front of you, you are "making believe" if you claim you are concerned medically about every member of the family. It becomes clear after a year or two of clinical encounters that the patient is dealing with a physician who has medical data on every member of the family right at his finger tips.

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ERRATUM

Authors contributing to this Journal may have noted that for the past several months proofs of their articles have reached them in finished page form rather than in the galley proof form employed by us since the earliest issues of The Journal. While the new page proofs are a real improvement, the transition in proofing systems, which occurred for the February issue, allowed that a number of errors were published in two articles in that issue (*Spendlove DC, Ridgon MA, Jensen WN, Udall KS: Effects of waiting on patient mood and satisfaction. 24(2):200, 202;* and *Murray JP: Comparison of patient satisfaction among prepaid and fee-for-service patients. 24(2):203–207*). The editors regret these errors and are confident that our proofing procedures are sufficiently stabilized as to prevent recurrence. Revised reprints are available from the authors on request.