HEALTH CARE IN NICARAGUA

To the Editor:

I was surprised and disappointed to see “A Report on Health Care in Nicaragua” in the Family Practice Grand Rounds (Drickey R, Gin D, Rapp J: A report on health care in Nicaragua, J Fam Pract 1987; 24: 349-356). I do not believe it meets your own definition of the purpose of Grand Rounds, and I do not believe the report is necessary so that physicians would understand that war causes bad health. Thus, what is the purpose of this article? My interpretation is that the article was presented out of political motivations and obviously deals with a very controversial topic in our society. If its purpose was to garner support for the Sandinista government in Nicaragua, only the readers as a group can tell us what the impact has been. After reading the article, I felt that at best it disinfomed us, and at worst it was more propaganda from the Sandinista government. Here’s why I believe this.

What is the source of information? Many statements were made that are judgmental, and the way in which these judgments were reached is not stated. On p 349 Daisy Gin makes the statement, “... health facilities that were targeted by Contra activity.” How does she know that they were targeted? Could the facilities have been victims of an attack and not specifically designated as targets? Were health facilities marked as such, so that during an attack everyone, Sandinistas and Contras, would know what kind of facilities they were? This statement is highly political in nature, and if it is true, then it would be hard to justify continued support for the Contras regardless of one’s political views on the US involvement. This assertion is again repeated on p 353 and even implies “health workers ... are targeted.” If this statement is not more propaganda, where is the support for these assertions? Finally, I believe the statement that “The health care system serves as a stabilizing force in the country” is either naive or arrogant because I do not believe that health care systems, other than offering improved nutrition, sanitation, and immunization status, have much impact on a culture’s well-being.

Next, on p 350, Dr. Jonathan Rapp presents “some statistics reflecting the health of the Nicaraguan people under the two systems.” The source of these statistics is not given. Why not? I am sure that the public health measures instituted by the government have had a positive impact on the health of those citizens who the “war during the revolution had a devastating effect on” (p 350). Thus, it appears to be self-serving to compare current statistics on health with data from a time when the country was in the midst of a revolution, as is done in Table 1. A more realistic comparison would be the current data compared with similar data taken from a time before the revolution was in full swing.

Again on p 353, numbers are given on casualties without sources of information, and a very political statement is made: “The Contras operate mainly by terrorizing the rural population with attacks and ambushes on small towns.” If the sources of information are the citizenry, then how was the information obtained from them, i.e., controlled by the government, through government interpreters, in their homes, etc? Nothing is said about the health of political prisoners or about those injured, killed, or missing because they opposed the Sandinista government.

In conclusion, I do not believe this article has a place in The Journal of Family Practice and appears to have a political agenda. Warfare is harmful to any culture, especially in the country where it takes place, and this article does nothing to further our knowledge of this fact.

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The preceding letter was referred to Dr. Drickey and colleagues, who respond as follows:

We appreciate the opportunity to respond to Dr. Mongan’s comments regarding our Family Practice Grand Rounds on health care in Nicaragua.

Dr. Mongan believes that the article does not meet “your own definition of the purpose of Grand Rounds.” As stated in the The Journal’s Information for Authors, Family Practice Grand Rounds are “normally based on an interactive teaching conference ... illustrating one or more of the basic concepts of family medicine.” In the Family Health Center at San Francisco General Hospital, we serve many refugees and immigrants from Central America. To understand and work within the entire context of their lives is imperative. Central Americans in San Francisco remain very connected to their roots in their countries of origin. As community-oriented health workers and as responsible citizens, we are attempting to learn, therefore, about what is happening in Central America.

Dr. Mongan says he does “not believe the report is necessary so that physicians would understand that war... continued on page 328
HYDERGINE LC
(ergoloid mesylates) 1 mg capsules

Indications: Symptomatic relief of signs and symptoms of idiopathic decline in mental capacity (decline in orientation, recent memory, emotional lability, self-care, apparent motivation) in patients over sixty. It appears that individuals who respond to HYDERGINE therapy are those who would be considered clinically to suffer from some ill-defined process related to aging or to have some underlying deteriorating condition, such as primary progressive dementia. Alzheimer's dementia, senile dementia, multi-infarct dementia. Before prescribing HYDERGINE® (ergoloid mesylates), the physician should exclude the possibility that signs and symptoms arise from a potentially reversible condition, particularly delirium and dementiform illness secondary to systemic disease, (e.g., nutritional, metabolic, infectious), disease, or primary disturbance of mood. Not indicated for acute or chronic psychosis regardless of etiology (see Contraindications).

Use of HYDERGINE therapy should be continually reviewed, since presenting clinical picture may evolve to allow specific diagnosis and specific alternate treatment, and to determine whether any initial benefit persists. Modest but statistically significant changes observed at the end of twelve weeks of therapy include: mental alertness, confusion, memory, orientation, emotional lability, self-care, depression, anxiety/aversions, cooperation, socialization, appetite, dizziness, fatigue, bothersomeness, and overall impression of clinical status.

Contraindications: Hypersensitivity to the drug; psychosis, acute or chronic, regardless of etiology. Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing HYDERGINE (ergoloid mesylates) preparations.

Adverse Reactions: Unfavorable side effects have not been found. Some transient nausea and gastric disturbances have been reported, and sublingual irritation with the sublingual tablets.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3-4 weeks.

How Supplied: HYDERGINE LC (liquid capsules); 1 mg, off-white, embossed "HYDERGINE LC" 1 mg, on one side, "A" other side. Packages of 100 and 500. (Encapsulated by R. F. Scherer, N.A., Clearwater, Florida 33318).

HYDERGINE (ergoloid mesylates) tablets (for oral use): 1 mg, round, white, embossed "HYDERGINE 1" on one side, "A" other side. Packages of 100 and 500.

HYDERGINE (ergoloid mesylates) sublingual tablets: 1 mg, oval, white, embossed "HYDERGINE" on one side, "A" other side. Packages of 100 and 500.

HYDERGINE liquid: 1 mg/ml. Bottles of 100 mg with an accompanying dropper graduated to deliver 1 mg.

Before prescribing, see package circular for full product information.

References

INITIAL PRESCRIPTION FILLING

To the Editor:

I agree with Dr. Krogh and Dr. Wallner that initial prescription filling is difficult to measure, especially when no central clearinghouse exists where all filled prescriptions can be collected and checked. Their survey of initial compliance using orange prescription pads was successful, but undoubtedly some compliant patients were missed because their pharmacists refused to participate. Perhaps a more reliable method of
RESULTS OF REMINDING FAMILY PHYSICIANS ABOUT ADMINISTRATION OF FLU VACCINE

To the Editor:

As influenza vaccination time approaches, we would like to share a study the nurses in our office did last fall with the consent of one of our senior physicians. We decided to see what effect reminding the residents and staff physicians in our family practice office would have on their requesting that influenza vaccine be administered to their patients.

For two weeks we attached a slip of paper on which was printed, "Do you want this patient to have flu vacc-

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The wart medicine you can recommend with complete confidence.

Because you know the importance of preventing autoinoculation as well as the transmittance of the wart virus, you may wish to recommend Compound W®. Compound W contains Salicylic Acid 17% (the maximum strength your patients can buy) in a flexible collodion vehicle which has been classified safe and effective to remove warts. Compound W, in liquid and gel, is an economical way for your patients to eliminate infectious and embarrassing warts. For the past 25 years, Compound W has been an effective and safe wart remedy. You can recommend it with complete confidence.

References

Hunter E. Woodall
Fairfax, South Carolina
LETTERS TO THE EDITOR

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To the Editor:

Flexible sigmoidoscopy permits the examination of more colon than the rigid instrument with less discomfort to the patient. Early in our experience with the new device, it was clear that one obstacle still needed to be overcome. Precisely because the tip of the sigmoidoscope is flexible and flat, it can be difficult and painful to insert into the anal canal of many patients, especially those with hemorrhoids, proctitis of any cause, obesity, or patients who are extremely anxious and have increased sphincter tone.

We have solved this problem by using a simple, disposable plastic anoscope. The anoscope is gently inserted to its full depth (about 10 cm) and the trochar withdrawn. The sigmoidoscope is then inserted through the anoscope to a depth of 10 to 12 cm. The anoscope is withdrawn over the sigmoidoscope back to the control head, where it is left until the completion of the examination. The sigmoidoscope is then advanced in the usual manner. We have used this technique in 150 examinations with no difficulties. In fact, when used in conjunction with good technique for the remainder of the procedure, many patients will have a painless examination.

We have been pleased with the effectiveness, ease, low cost, and safety of this “Warshaw maneuver” and believe other physicians will find it very useful.

Timothy M. Empkie, MD
Ira Warshaw, MD
Department of Family Medicine
Brown University Providence, Rhode Island

Thomas T. Gilbert, MD
Providence, Rhode Island

 SCREENING FOR URINARY TRACT INFECTIONS IN ELDERLY WOMEN

To the Editor:

The article by Bertakis and Ross (Bertakis KD, Ross JL: Office evaluation of urinary tract infections in elderly women. J Fam Pract 1987; 24: 72-75) is interesting but beside the point. To screen for an asymptomatic disease that has been present more than three months (by their definition) is probably important, but certainly does not require speed. A less complex schema is to await the results of culture, and if there is any question about the result, reculture the urine. There is no particular rush to diagnose a process that causes no short-term problem and certainly no advantage to using (and paying for) less than the gold standard when the gold standard is also to be done.

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Albuquerque
WOEMEN’S ADJUSTMENT TO MARITAL SEPARATION

To the Editor:

In the article “The Impact of Daily Stressors on Women’s Adjustment to Marital Separation” (J Fam Pract 1987; 24:507–511), Oppenheimer concludes that “daily stressors are better predictors of psychological distress than the major life event of marital separation.” However, the study findings do not support this conclusion, and in fact, the design of the study does not allow for an assessment of the effect of marital separation or divorce on psychological distress. The study group consisted only of women who had experienced a separation or divorce sometime during the preceding three years. No women who had not experienced separation or divorce were studied. To determine the impact of this major life event, women who were exposed to it would need to be compared with women who were not exposed. Considering the individual variability in the length of time necessary to cope with and adjust to such a major life event, recency of the separation or divorce is probably not an adequate proxy measure of the impact of the event.

Even if one accepts the assumption that recency of separation or divorce does reflect the impact of the event, there is a problem with the conceptual base of the analysis in this study. On the basis of the results of a multiple-regression analysis, Oppenheimer concludes that daily stressor frequency is associated with psychological distress on follow-up, while recency of separation is not. However, including stressor frequency and stressor intensity as independent variables in the multivariate model may obscure the association of recency of separation or divorce with distress. This confounding would occur if daily stressors constitute an intervening or intermediary variable in a causal pathway between recency of separation or divorce and distress.1 In the introduction the author speculates that daily hassles or stressors might mediate the relationship between the event and distress; if this were true, including stressors as an independent variable in the regression analysis would partially or completely cancel out the variance in distress that is explained by recency of separation or divorce.

To explore the possible mediating role of daily stressors, additional analysis is necessary. The correlation of stressors with recency of separation or divorce should be determined. Then the association of recency with distress should be examined with and without the daily stressor variables included in the regression model. The hypothesis of a mediating effect of daily stressors would be supported by the finding of a correlation of stressors with recency and by the finding of an association of recency with distress that decreased or disappeared when stressor variables were added to the regression equation. Unfortunately, in this study daily stressors are conceptualized as mediators of the relationship between marital separation or divorce and distress, but are analyzed as confounders of this relationship.

Robert L. Blake, Jr., MD
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Reference

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

It appears that Dr. Blake misinterpreted the purpose and therefore the design of my study. First, he faults the design by saying that “. . . the design of the study does not allow for an assessment of the effect of marital separation or divorce on psychological distress.” He continues by asserting that a control group is necessary to answer this question. Blake is correct on this point, if I had wished to examine the effect of marital separation on psychological distress. However, this relationship is no longer an interesting research question, as it has

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LOZOL® indapamide 2.5 mg tablets

BRIEF SUMMARY

DESCRIPTION: LOZOL (indapamide) is an oral antihypertensive/diuretic.

INDICATIONS AND USAGE: LOZOL is indicated for the treatment of hypertension, alone or in combination with other antihypertensive drugs.

WARNINGS: Hypokalemia occurs commonly with diuretics. In general, diuretics should not be given concomitantly with lithium.

PRECAUTIONS: GENERAL: 1. Hypokalemia and Other Fluid and Electrolyte Abnormalities: Serum electrolytes should be performed at appropriate intervals. In addition, patients should be observed for clinical signs of fluid or electrolyte imbalance, such as hypotension. 2. Electrolyte determinations are particularly important in patients who are vomiting excessively or receiving parenteral fluids, in patients subject to electrolyte imbalance (including those with heart failure, kidney disease, and cirrhosis), and in patients on a salt-restricted diet. The risk of hypokalemia secondary to diuresis and nausea is increased when larger doses are used, when the diuresis is brisk, when severe cirrhosis is present and during concurrent use of corticosteroids or ACTH.

INTERACTIONS: Concurrent use of a diuretic with other antihypertensive drugs, such as increased ventricular irritability. Differential hypokalemia may occur in edematous patients: the potassium level may be lower in the distal convoluted section of the tubule, in rare cases when the hypokalemia is life threatening. However, in acute salt depletion, appropriate replacement is the first step. Dose adjustment that may be necessary during treatment is generally mild and usually does not require specific treatment. Treatment of hyponatremia, hypochloremic alkalosis, and hypokalemia. Elec­

LIVE INTERACTIONS: 1. Hypokalemia and Other Fluid and Electrolyte Abnormalities: Serum electrolytes should be performed at appropriate intervals. In addition, patients should be observed for clinical signs of fluid or electrolyte imbalance, such as hypotension. 2. Electrolyte determinations are particularly important in patients who are vomiting excessively or receiving parenteral fluids, in patients subject to electrolyte imbalance (including those with heart failure, kidney disease, and cirrhosis), and in patients on a salt-restricted diet. The risk of hypokalemia secondary to diuresis and nausea is increased when larger doses are used, when the diuresis is brisk, when severe cirrhosis is present and during concurrent use of corticosteroids or ACTH. Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis, such as increased ventricular irritability. Differential hypokalemia may occur in edematous patients: the potassium level may be lower in the distal convoluted section of the tubule, in rare cases when the hypokalemia is life threatening. However, in acute salt depletion, appropriate replacement is the first step. Dose adjustment that may be necessary during treatment is generally mild and usually does not require specific treatment. Treatment of hyponatremia, hypochloremic alkalosis, and hypokalemia. Electrolyte and fluid balance should be evaluated carefully. There is no specific antidote. An evacuation of the bowel may be necessary to initiate therapy. In severe instances, hypotension and depressed respiration may be observed. If this occurs, support of respiration and cardiac circula­tion should be instituted. There is no specific antidote. An evacuation of the stomach is recommended by emesis and gastric lavage after which the electrolyte and fluid balance should be evaluated carefully.

HOW SUPPLIED: White, round film-coated tablets of 2.5 mg in bottles of 100, 1,000, and in unit-dose blister packs, boxes of 100 (10 x 10 strips).

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

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LETTERS TO THE EDITOR

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was well-documented that persons who have experienced marital separation appear more pathological on virtually every outcome measure than persons who have not experienced marital separation. In addition, implicit in the group comparison method is the assumption that persons who have experienced marital separation comprise a homogeneous group. Research has demonstrated that there is variability in the amount of distress reported following marital separation.

Thus, the interesting research question becomes: Given that marital separation has occurred, what are the variables that predict distress following marital separation? This question is exactly that which my study was designed to answer. Since I investigated predictors of distress within a group, no separate control group is needed.

Blake's second point, that "recency of separation or divorce is probably not an adequate proxy measure of the impact of the event," is not supported by the divorce literature or crisis theory, which served as the theoretical basis for my investigation. Within a crisis theory model, separation or divorce is a stressful life event that results in a temporary state of psychological disorganization and disequilibrium. Generally, the acute distress lasts for a period of several weeks to a few months, although research has shown that the disorganizing experience of divorce can extend over several years. However, studies have suggested that the psychological sequelae of marital separation is greatest in the first six months following the event, and that women who have been separated three or more years do not significantly differ from their married counterparts on indices of psychological distress. Thus, the decision to operationalize the impact of marital separation by the recency of the event was both theoretically and empirically derived.

Third, Blake contends that there is a conceptual problem with my study. He states, Oppenheimer concludes that daily stressor frequency is associated with psychological distress on follow-up, while recency of separation is not." The key word here is association. A correlation between two variables does not suggest that they are causally related. The conceptual problem seems to be in Blake's apparent assumption that my study was designed to demonstrate that daily hassles cause psychological distress. My findings indicated that daily hassles are better predictors of psychological distress than the mere fact that separation has occurred, thus making this clinically useful information for physicians. Furthermore, I acknowledge in the discussion the potential confounding of these variables by stating that a limitation of this study was that both measures were self-reported, thus allowing the possibility that high levels of psychological distress may have resulted in increased perceptions of events as stressful (p. 510). Thus, Blake's statistical argument seems superficial given that invalid assumptions were made with respect to the rationale for the study, the hypotheses tested, and the research design.

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References

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