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.

ELDER ABUSE

To the Editor:

The Family Practice Grand Rounds in the June issue of The Journal on elder abuse (*Trilling JS, Greenblatt L, Shephard C: Elder abuse and utilization of support services for elderly patients. J Fam Pract 1987; 24:581–587*) was stimulating. Unfortunately elder abuse is a common problem, estimated to occur with 10 percent of the elderly population.[1] I was pleased to see the family genogram (Figure 1) used to help explain two overwhelming aspects of elderly abuse. First is delay in diagnosis and treatment, and second is patient and family denial.

Perhaps further family genogram analysis in light of family systems theory would help illuminate this tragedy.[2,3] For brevity, let's concentrate upon the key players; the abused and the abuser (a conflictual relationship represented by the wavy diagonal line). Mr. B. (the presumed abuser) has lost his father. These circumstances often shed light. Does he blame his mother? If so, does he direct this blame toward his mother-in-law (herself widowed)? Also, Mr B.'s family experience concerning abuse would be significant information. Was he abused? Was there abuse in his family?

Turning to the abused, Mrs. C., does she have a family experience of abuse prior to Mr. B.? Lastly, Mrs. C. is a widow. Has she successfully completed her grieving process?[4] If not, does she experience residual guilt and blame herself for her husband's death,

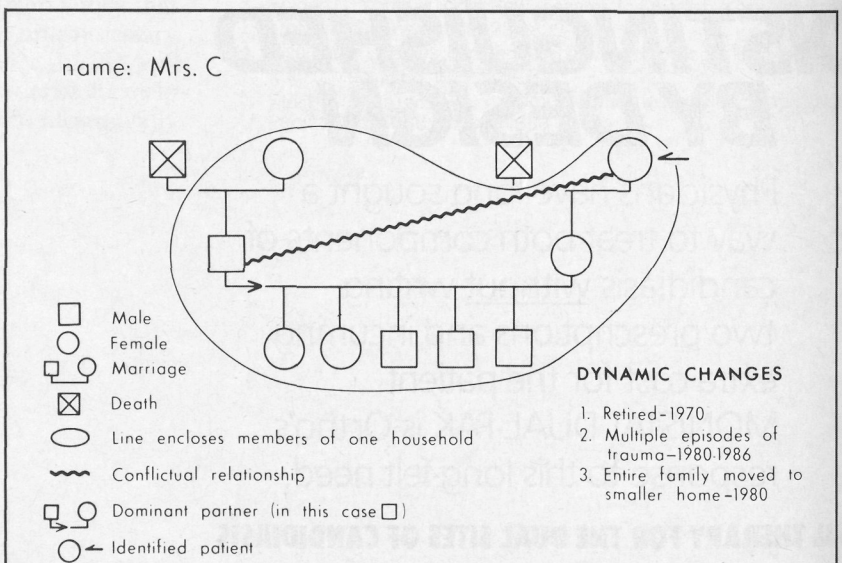

Figure 1. Family genogram. *From Trilling JS, Greenblatt L, Shephard C: Elder abuse and utilization of support services for elderly patients. J Fam Pract 1987; 27:581–587*

continued on page 438

continued from page 436

thus feeling deserving of the son-in-law's abuse?

Analysis by means of family systems theory can expand upon the family genogram approach and help to further explain the basis of this serious problem. As Trilling points out, the denial is often the result of fear, ignorance, and apathy or helplessness. Understanding the family dynamics can often, as Trilling so aptly states, lead to "a determination of its etiology" and "help the abuser as well as the abused in establishing the best possible course of posthospital therapy."

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TREATMENT OF PRURITUS

To the Editor:

With regard to the article by Richard Rubenstein (*Pruritus: A new look at an old problem. J Fam Pract 1987; 24:625–629*), he mentions in passing the use of "scalding hot water."

This means of treatment is more effective than Dr. Rubenstein acknowledges and will give relief from the itching for 4 to 24 hours. Because it is somewhat painful, it is limited to use with older children and adults and when the itching is confined to reasonably limited areas of the body.

To do the treatment properly, the patient is told to take a small towel and hold it under the hot water tap. The water must be hot enough that when the patient wrings out the towel, it is found to be distinctly uncomfortable. The patient is told to then rapidly fold the towel three or four thicknesses and apply it to the itching area. Again, the sensation should be one of distinct discomfort for approximately 10 seconds. If the discomfort persists longer than that, the towel should be removed immediately to prevent scalding. The towel should then be left on for a total of approximately one minute.

Immediately thereafter the area will be both pain free and itch free for a period of some number of hours. I have not found that treatment has any particular effect on whatever pathological process caused the irritation.

It would be nice to do a well-controlled double-blind study on this treatment, but I suspect that such a study would pose methodologic difficulties. Physicians and patients may wish to give this an empiric tryout period.

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CASE MANAGEMENT AND GATEKEEPING

To the Editor:

I take issue with several points raised by Dr. Essman in his letter concerning gatekeepers in primary care (*Essman TM: Gatekeepers in primary care, letter. J Fam Pract 1987; 24:574*). *Case manager* is not just a sanitized synonym for *gatekeeper:* the terms describe related but different and equally important roles.

Ideally a case manager is a generalist who can provide primary care and who can coordinate, interpret, and advise on necessary secondary and tertiary care as an advocate for a patient and his family. To do this

continued on page 440

continued from page 438

"without regard to any costs to society" or for costs to the patient would be neither responsible nor in the best interests of the patient or the society.

To be a gatekeeper, whether in a strictly defined sense or in a broad conceptual framework, means to provide cost-effective fiscally responsible care, without sacrificing quality. This is compatible with the physician's obligation "to do all [he] can for [his] patient" (within an individualized context) but not "without regard to any costs to society."

That more tests, more medications, more referrals, more hospitalizations often do not translate into better care and may, in fact, have exactly the opposite outcome has been well demonstrated.[1–5] I agree with Dr. Essman that "it is important to teach residents cost-effective medical treatment." We will only confuse them more, and fail, if we teach them one standard and expect them to perform at another.

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DIAGNOSIS OF ECTOPIC PREGNANCY

To the Editor:

I enjoyed reading Dr. Andolsek's article on ectopic pregnancy from the family physician's point of view: diagnosing ectopic pregnancy *before* it ruptures (*Andolsek KM: Ectopic pregnancy: 'Classic' vs common presentation. J Fam Pract 1987; 24:481–485*). Understandably, it is a critical diagnosis to make as early as possible. Her case reports were most instructive.

In at least two places in the article, however, she refers to urine pregnancy tests as unsuitable for diagnostic use in ectopic pregnancy, since they are "less sensitive" than serum pregnancy tests. I would point out that there are now available in the office laboratory some very sensitive urine tests for pregnancy, including the ecotopic variety.[1]

Although qualitative by design, many enzyme-linked immunosorbent assays (ELISA) employ monoclonal antibody specific for the beta-subunit of the human chorionic gonadotropin (hCG) molecule. In ectopic pregnancy, as in normal gestation, hCG is present in both urine and serum, albeit in lower concentrations and at times demonstrating a high beta-hCG subunit-whole hCG unit ratio. Sensitivity of the test is the crucial element in testing, not urine vs serum substrate. Newer ELISA tests are routinely sensitive to 50 mIU/mL or less of hCG. (One test claims a sensitivity down to 20 mIU/mL.[2]) This concentration is consistent with common estimates of the level of hCG at one week following implantation.

Such technology has been taken beyond theoretical considerations. In a simple but convincing study, Buck and colleagues[3] correctly diagnosed 30 of 30 cases of ectopic pregnancy with four commercially available ELISA urine tests in an ambulatory setting. Concomitantly, they avoided falsely diagnosing any of 16 nonpreg-

continued on page 522

continued from page 440

nant women presenting with similar complaints serving as controls.

Thus, we have come (rapidly) a long way from the earlier days of "slide" urine pregnancy tests, the sensitivities of which only began in the range of 1,000 to 2,000 mIU/mL. Office physicians are no longer bound so tightly to hospital or reference laboratories with their technical equipment. Furthermore, although an ultimately sensitive radioimmunoassay test may be needful in some cases (eg, to quantitate falling hCG titers in a treated molar pregnancy or when clinical judgment supervenes in a doubtful case), we have arrived at a point at which we may usually diagnose ectopic pregnancy at the bedside with readily available office laboratory technology.

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3. Buck RH, Norman RJ, Reddi K, et al: Various methods for determining urinary choriogonadotropin evaluated for the early diagnosis of ectopic pregnancy. Clin Chem 1986; 32:879–882

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

To the Editor:

Dr. Fletcher reminds us that optimal laboratory use requires knowledge of available options. The physician needs to take into account the abilities of the individual performing the test, the sensitivity and specificity of the test, the cost, patient acceptability, and the likelihood the result will be believed by the physician.

Dr. Fletcher points out that family physicians no longer need to be tied to hospitals or reference laboratories—a point with which I wholeheartedly agree. Either the more sensitive urine tests he describes, or a sensitive serum pregnancy test, such as the ICON which we use, are available for the office. Urine substrate vs serum are theoretically comparable. However, by using the serum pregnancy test we avoid the practical distinction of needing a relatively concentrated sample (or needing to confirm with a concurrent specific gravity determination) or the obfuscation of a poorly obtained clean catch specimen, urinary cloudiness, or proteinuria. The cost to us for either test is virtually identical—approximately $2.50 per test. However, start-up costs to convert to using the newer urine tests would be $200 to $300.

Finally, most of our physicians retain an emotional distrust of the urine pregnancy test. If the test were negative, most would order the serum pregnancy test "just to make sure." As sensitive urinary tests become more widespread, remain stabile on the market, and less costly, I suspect they will gain wider physician acceptance.

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PATIENTS' EXPECTATIONS AND FAMILY CONFERENCES

To the Editor:

First, we would like to thank Dr. Thomas Schwenk for drawing attention to our work in his guest editorial in the May issue of *The Journal of Family Practice* (*Caring about and caring for the psychosocial needs of patients. J Fam Pract 1987; 24:461–463*). While we agree with many of his comments regarding emphasis on the therapeutic aspects of the physi-

continued on page 524

continued from page 522

cian-patient relationship, we feel that he fails to acknowledge several important conclusions supported in the Hansen et al study.[1] For example, one of the psychosocial skills that patients definitely do want is a physician who allows them time to discuss psychosocial problems, especially when the patient perceives that talking about such things is helpful. In Dr. Schwenk's zeal to restrict the scope of behavioral sciences skills training in the family practice, he appears to ignore what our data say regarding what patients want from family physicians, namely, listening skills, the ability to provide some advice and treatment for psychosocial problems and to refer, if necessary, for these problems.

We also feel that Dr. Schwenk places the wrong emphasis on the findings from the Kushner et al study[2] regarding patients' interest in family conferences. Dr. Schwenk writes that this study "described patients' desire for family physicians to convene family conferences related to specific psychosocial problems." While it is true that we looked at patients' desire for family conferences for "psychosocial problems," we also examined their desire for family conferences for "medical problems." While our patients did indicate a high degree of interest in family conferences for serious behavioral problems, they expressed even more desire for family conferences in cases of serious medical illness. In this research we have taken pains to draw the distinction between family therapy and a family conference with the physician. In no way do we mean to imply, nor do we feel our data imply, that patients want "treatment" for their psychosocial problems in the family conferences with their physician. Rather, we view the family conference more as a logical outgrowth of Schwenk's "therapeutic aspects of the physician-patient relationship." Specific mental health skills," we agree, fall more legitimately within the purview of mental health professionals. We feel that the family conference is an ideal way for the physician to provide "concern, support, explanations, advice, suggestions, and 'professional handholding,' " as suggested by Schwenk.

Careful reading of these two studies and the others referenced in Dr. Schwenk's editorial indeed tell us as much about what patients want (and thus what family physicians should be prepared to provide) as what patients do not want.

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SPORTS MEDICINE CURRICULUM AND REHABILITATION EXERCISES

To the Editor:

The American Academy of Family Physicians has endorsed core curriculum guidelines on sports and recreational medicine for family practice residents. As facilitator of the sports medicine component at our Family Practice Residency Program, I have become aware that residents appear to receive minimal exposure to rehabilitation and exercise as a part of a treatment program. Rarely do residents suggest rehabilitating an injured area following an acute injury.

To confirm this perception, I worked with our chief resident, who

continued on page 526

continued from page 524

TABLE 1. ANKLE REHABILITATION EXERCISES

After an ankle sprain the joint remains weak and prone to repeat injury for the following six months. Simple exercises that take no more than than 30 minutes a day can significantly lessen this risk.

1. Alphabet exercises: Hold your foot in the air and write the alphabet twice. This duplicates every motion the ankle makes.
2. Paint can exercises: Move a paint can or similar object weighing 10 lb across a tile floor to the left and then back to the right. By pivoting at the ankle you strengthen it for both inversion and eversion (turning under and turning out).
3. Isometrics: Step down on a tennis ball with the ball of the foot and hold for 10 seconds. Repeat 10 times. Lift up your toes against a table or unmovable object and hold for 10 seconds. Repeat 10 times.
4. Cord exercises: Use surgical tubing, an inner tube, or bungi cords to loop around your anterior foot. While holding resistance with the cord, stretch your foot inward, outward, and in all possible motions.
5. Balance: Your sense of balance is often altered by a previous ankle injury. Many athletes recover more quickly by practicing standing on a balance board, skate board, or simply the side of their feet until this exercise is not difficult.

surveyed her peers asking the question, "Do you prescribe specific rehabilitative exercise for patients after an acute injury of the ankle, knee, or shoulder?" Of our 18 residents, only six (two in each residency year) responded that they prescribe such exercises; this number was not increased by completion of an orthopedics elective. This is disappointing, as rehabilitation is one of the seven expected skills in the sports medicine core curriculum.

Based on these results, a simple set of rehabilitation exercises was developed for the ankle, shoulder, knee, and neck. These were then placed in a centrally located area. Through conferences and direct feedback from the above survey, residents were made aware that specific patient instruction material for these injuries was available. Currently, these specific exercises are in their third reprinting. Sample exercises for rehabilitation of the ankle are detailed in Table 1; exercises developed for rehabilitation of the shoulder, knee, and neck are available on request from the authors.*

We are encouraged that, by providing information to the residents about these rehabilitation exercises, the residents will be more aware of the exercises and will feel at ease giving at least printed information to their patients. Perhaps in the future an assessment of their comfort with giving more specific instructions to patients recovering from acute injuries will be possible.

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