TOPICAL THERAPY FOR SUPERFICIAL WOUNDS

To the Editor:

I read with great interest the well-done study on the use of topical antibiotics, antiseptics, and wound protectants (*Leyden JJ, Bartelt NM: Comparison of topical antibiotic ointments, a wound protectant, and antiseptics for the treatment of human blister wounds contaminated with Staphylococcus aureus. J Fam Pract 1987; 24:601–604*). I was glad to see such good work being done in an area imporant to office practice.

I believe that further conclusions are in order from the data provided. On the basis of demonstration of equal efficacy and wound healing with the neomycin-polymyxin B-bacitracin ointment as compared with polymyxin B-bacitracin ointment, it would seem justifiable from a clinical standpoint to conclude that the latter ointment, which lacks the frequent topical sensitization seen with neomycin, should be used in preference to the former triple antibiotic ointment. I feel that the authors' conclusions centering around the triple antibiotic ointment gave the impression that this ointment was favored over the bacitracin-polymyxin combination. I have had excellent luck with the bacitracin-polymyxin product in clinical practice. It would seem that the data from this study would corroborate the recommendations of many dermatologists to avoid the use of topical neomycin, as equal efficacy was demonstrated in terms of actual wound healing, if not in time to sterilization of the wound.

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

In reply to Dr. Sheeler's letter on our study comparing various topical antimicrobial and antibiotic therapies for superficial wounds contaminated with pathogenic bacteria, I would make the following points.

1. The main thrust of our conclusions was that topical antibiotic ointments were more effective than a variety of topical antimicrobial agents in that the latter have a potential for toxicity to wounds and can delay wound healing and that topical antibiotics are more effective in suppressing Staphylococcus aureus and S pyogenes. We did not attempt to settle the issue of whether neomycin should or should not be used.

2. Neomycin is not a potent allergen and is associated with rather low levels of contact allergy when used briefly or intermittently. Prolonged use for stasis ulcers, external otitis, or chemically inflammed skin can result in increased levels of contact allergy.[1,2]

We agree with Dr. Sheeler that the combination of bacitracin-polymycin is a very efficacious product. The addition of neomycin can also be used safely in the appropriate clinical setting.

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2. Prystowsky S, Nonomoura J, Smith R, Allen A: Allergic hypersensitivity to neomycin. Dermatol 1979; 115:713–715

ENDOCARDITIS AND MITRAL VALVE PROLAPSE

To the Editor:

The recent article by Birrer et al (*Birrer R, Mitchell K, Salvatore V: Infective endocarditis. J Fam Pract 1987; 24:289–295*) provided an excellent clinical review of endocarditis.

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I believe, however, that the role of mitral valve prolapse was understated. The relative risk for mitral valve prolapse is estimated to be 4.8.[1] While the prevalence of mitral valve prolapse in the general population is 4 to 5 percent,[1,2] this condition is present in as many as 29 percent of cases of infective endocarditis.[3] With the prevalence of rheumatic heart disease declining, mitral valve prolapse will be the risk factor for infective endocarditis most often encountered by family physicians. Family physicians should become adept in making the diagnosis of mitral valve prolapse in the primary care setting so that they can identify those mitral valve prolapse patients who are at greatest risk for infective endocarditis. According to MacMahon et al, 89 percent of the risk exists in the mitral valve prolapse patients with systolic murmurs.[4]

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3. McKinsey DS, Ratts TE, Bisno AL: Underlying cardiac lesions in adults with infective endocarditis. The changing spectrum. Am J Med 1987; 82:681–688
4. MacMahon SW, Hickey AJ, Wilcken DEL, et al: Risk of infective endocarditis in mitral valve prolapse with and without precordial systolic murmurs. Am J Cardiol 1986; 58: 105–108

FREON 12 AND VERRUCA LESIONS

To the Editor:

I am writing you in response to the many letters and telephone calls that Mary Wester and I have received since publication of our article, "Use of Freon 12 in Treating Verruca Lesions" (*J Fam Pract 1987; 25:73–77*). I would like to state that to my knowledge dichlorodifluoromethane (Freon 12) has never been indicated, used, or distributed for use in clinical medicine prior to this time. It is currently distributed for laboratory use only by several scientific companies. I had some difficulty in obtaining the product for our clinical work.

I have recently discussed with a major packager the need for marketing Freon 12 and chlorodifluoromethane (Freon 22), which I have recently been using. We are currently working to develop a stainless steel spray nozzle for a more precise delivery of spray to the skin, and for a more professional appearance of the spray apparatus. In addition, I have found that a taller neoprene cone is needed to contain the Freon properly and prevent splattering and spillage. The manufacturer hopes to have a kit available for distribution of these items and instructional booklets within the next six months.

We are also very enthusiastic about the use of Freon 22. This is a slightly colder Freon, −41 °C boiling point vs −29 °C for Freon 12. Freon 22 has a higher vapor pressure and needs a reinforced, somewhat more expensive can for packaging and storage.

For more information regarding the successful clinical treatment of verruca lesions, actinic keratosis, seborrhoic keratosis, condyloma acuminatum, and senile lentigines with the Freons, I suggest that interested physicians send their names and addresses to my address: Dr. Ronald A. McDow, 7356 Cabot Drive, Nashville, TN 37209. We will be happy to forward information later this year when the kit becomes commercially available.

Ronald A. McDow, MD
Nashville, Tennessee

HEALTH CARE IN NICARAGUA

To the Editor:

It is with interest that I read the letter to the editor by Patrick Mongan, MD, criticizing "A Report on Health Care in Nicaragua" by Drickey et al in the Family Practice Grand Rounds (*J Fam Pract 1987; 24:349–356*). He feels "that at best it disinformed us," and yet offers no specifics to counter this information. I am impressed (negatively so) with the consistency of such criticism presented by people who have not been to Nicaragua to observe the reality that nation is experiencing. *American Medical News,* in its February 13, 1987 issue, provided equal time to both sides of the argument from the physician viewpoint. Those having been to Nicaragua uniformly related specifics as to how "The Contras operate mainly by terrorizing the rural population with attacks and ambushes on small towns." Those who did not want to believe this reality suggested vague rhetoric to discount such specifics or even justify them.

My personal experience as a physician in the countryside (and war zone) of Nicaragua (August 1984 to November 1985, June to July 1987) leaves no doubt that the Contras attack primarily civilian targets and that, in fact, "health workers . . . are targeted." Such attacks occur daily and continue to be reported even as attempts are being made toward hammering out a Central American peace accord.

What impressed me most, beyond the tremendous strides made in preventive medicine, is the capability of individuals carrying out health responsibilities in the midst of such danger. Most recently I appreciated a 16-year-old male "nurse auxiliary" who worked side by side with me seeing 50 patients (each) every day. His handling of a somewhat difficult delivery, including oxytocin drip, was phenomenal, and I was impressed with the medical school-type questions he answered along the way. I feel we have much to gain from such as "A Report on Health Care in Nicaragua" and will look forward to expansion of this concept.

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HEALTH CARE DECISIONS FOR AN INCOMPETENT PATIENT

To the Editor:

As illustrated by the Family Practice Grand Rounds case study *(Smith MA, Green LA, Ward P: Aggressive therapy in the care of the critically ill patient. J Fam Pract 1987; 25:119–124),* the proxy decision-making process can be difficult when a patient is incompetent. Nevertheless, there exists in the article an erroneous presumption that power of attorney legally empowers the holder to make health decisions for an incompetent patient.

Power of attorney[1] legally authorizes a person to facilitate the personal and financial transactions of another competent individual. As soon as that individual is deemed to be incompetent, however, the person holding power of attorney loses his or her authority to act as such. A durable power of attorney,[1] on the other hand, similarly entrusts an individual with the personal and financial considerations of another individual. The scope of this authority may be limited to health care decision making as cited in the article. In contrast with power of attorney, durable power of attorney attributes continuity of authority even when the patient becomes incompetent. As a result, the difference between the power of attorney and the durable power of attorney is semantically subtle but legally far-reaching.

If, indeed, the patient's friend actually had power of attorney (not durable power of attorney), her authority to act as a proxy decision maker terminated when the patient became incompetent. At this point, the friend could have been called on solely as a source of information on the patient's previously stated competent health care wishes without the legal agency to act as her proxy decision maker.

On the other hand, if the patient's friend had durable power of attorney, she had specific duties to fulfill. The proxy decision maker is charged with choosing the health care options that are most compatible with the patient's previously expressed written or oral directives. If no such preferences were ever elicited, a "substituted judgment,"[1] utilizing the patient's value system, determines the proxy's decision. Otherwise, if a proxy is allowed to make decisions based on his or her own value system, it would violate the medical team's attempt to preserve the patient's autonomy.

Physicians must know precisely what legal authority a potential proxy decision maker has prior to acknowledging his or her right to consent for another person. Further, the proxy's duties to carry out the patient's wishes should be clarified between the proxy and the medical team so that the patient's autonomous desires—not the proxy's—will be fulfilled.

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Reference

1. President's Commission for the Study of Ethical Programs in Medicine and Biomedical and Behavior Research: Deciding to Forego Life-Sustaining Treatment. Government Printing Office, 1983, pp 146, 147, 132–134