

USE OF FIRST NAMES

To the Editor:

The effort of Bergman and associates to ascertain patients' reactions to the use of first names or last names (Bergman JJ, Eggertsen SC, Phillips WR, et al: *How patients and physicians address each other in the office. J Fam Pract* 1988; 27:399-402) was an interesting study. Not having done such a broad study, who am I to object to their findings? Having acknowledged that, I would point out that there is a trap here that the younger physician would be wise to avoid: Those elders who feel that the use of "Mr. Lastname" or "Mrs. Lastname" is a sign of "proper" respect hold that feeling with considerable intensity; those who feel otherwise seem not so intense.

Quite probably, this is more of a geriatric problem in the field of professional etiquette. Out of long experience, older people grasp intuitively an implied transactional "parent → child" slant in the doctor-patient relationship. (Notice that I put the doctor on top!) As elders, they are more accustomed to the high end of that seesaw. Maybe the intuition is sharpened by a sense of insecurity related to their illness and a feeling of ignorance in the important area of their health. In my discussions with fellow elders concerning mode of address by physician, they ask me with considerable emphasis, "How would they like to be called by their first names?!" Relative age is a significant factor. Then, too, most elders are women. Beware: the resentment can get hot, yet stay pretty well hidden, and that's bad in itself.

It is hard to get into trouble if one starts off in the more formal mode and moves, only after discussion and with permission, to the more informal use of first names. With anyone over 60 years old (it seems to get worse as one moves up the decades), I suggest lots of circumspection and very clear discussion right up front. And as for medical personnel other than for the physician, using the first name with older people is an even worse problem, especially if the language or ac-

cent seems to have been imported from a land where rank and status are even more important than here.

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TREATMENT OF NAIL PUNCTURE WOUNDS

To the Editor:

I read with interest in the December issue Dr. Chesebro's report of *Pseudomonas* osteomyelitis in the foot of a 10-year-old boy (Chesebro MJ: *A complicated nail puncture wound. J Fam Pract* 1988; 27:640-641). I assisted in the management of three similar cases last summer at Cook County Hospital in Chicago. All involved infections caused by *Pseudomonas* following nail puncture wounds in children wearing sneakers.

I would make one amendment to Dr. Chesebro's discussion. She notes that "ciprofloxacin may show promise," and, indeed, an effective oral antibiotic instead of lengthy intravenous therapy for bone infections in children is very attractive. Unfortunately, because of irreversible arthropathy seen in juvenile animals given this drug, it is contraindicated in children, and intravenous therapy with aminoglycosides and surgical debridement is still necessary.

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To the Editor:

The case report of Chesebro¹ calls attention to what appears to be a distinct clinical entity: *Pseudomonas* cellulitis and osteomyelitis following nail puncture wounds through rubber-soled shoes. As the author reports, the infecting organism seems to reside in the spongy inner soles of well-used sneakers, tennis shoes, and so on.

The treatment program she advocates is fully consistent with recom-

mendations in the literature, but there is reason to believe that these instructions are seriously in need of reassessment. Some of them (soaking of wounds, sterile probing) have been passed on from one medical generation to the next without having been scientifically validated. For example, Fitzgerald and Cowan,² in a paper cited by Chesebro, recommend routine (as opposed to selective) probing of puncture wounds even though their own data show recovery of foreign material to be less than 3 percent (26 of 887) of such cases. The possibility that forceful irrigation or exploration of puncture wounds may drive foreign material deeper into the tissues or otherwise predispose to infection seems to be largely ignored.

Iodophor antiseptics are useful on intact skin, but there is little evidence that their benefits when applied to other tissues outweigh their cytotoxic effects.³ It appears that each generation of physicians must relearn some lessons articulated by Reid and Stevenson⁴ a half-century ago. Reid tells the story of a boy who was brought to his home with a cut thumb. The father was dismayed when the injury was treated only with cleansing, conservative debridement, irrigation under running water, and a dressing. He was amazed when it healed uneventfully. "The father, like thousands of other people of our generation, had been imbued since birth with the necessity of using iodine or some antiseptic to kill the germs in such a wound. He had never seen a wound like that heal without getting red or painful. . . . To him the one essential on such an occasion had always been to kill the germs at whatever cost in pain, suffering, and infection." We are more sophisticated today, but the basic principles of wound healing remain the same. The use of prophylactic antibiotics is advocated for nail puncture wounds largely on the basis of evidence from other types of injuries, and the choice of agents is largely empirical. The author mentions ciprofloxacin; using it in nail puncture wounds through rubber-soled shoes is theoretically attractive because it is active against

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some *Pseudomonas* species, the agents most likely to cause serious infections in this setting. Clinical trials will be needed, however, before this drug can be advocated with confidence.

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DISINFECTION OF ENDOSCOPES

To the Editor:

For the past ten years, I have been involved with the practice and teaching of gastrointestinal endoscopy in the office. Since 1984, I have been chairman of the American Academy of Family Physicians' annual course on flexible sigmoidoscopy. During these experiences, it became apparent that the issue of endoscopic cleaning and disinfection was an area of special need. This was reiterated more recently by Katner et al (*Katner HP, Buckley RL, Smith MU, Henderson AM: Endoscopic cleaning and disinfection procedures for preventing iatrogenic spread of human immunodeficiency virus. J Fam Pract* 1988; 27:271-276).

As a survey study, it highlighted the importance of this issue among American Academy of Family Physicians members. The AAFP is correctly involved with this area, and since 1983 has participated in a joint committee with the American Society for Gastrointestinal Endoscopy specifically designed to address the issues of flexible sigmoidoscopy

in primary care. As a member of that committee and editor of the textbook created by that committee,¹ I can report that I will be fortifying our section on cleaning and disinfection for the second edition, which will be published in 1989.

The Katner et al study has stimulated some correspondence to the Academy that expresses a concern that the entire AAFP membership should be urgently alerted on the basis of the findings in this article. While commending the authors for an important and well-conceived study, let me point out that there is some controversy regarding the so-called state of the art in disinfection of gastrointestinal endoscopes.

Almost all of this controversy reflects anxiety regarding the risk of iatrogenic AIDS and hepatitis. Fears of these diseases led to the change in recommendations for cleaning and disinfection. During the 1970s and early 1980s, there were no uniform guidelines for cleaning and disinfection. In fact, hundreds of thousands of endoscopic procedures were performed in this country with cleaning alone. It is probable that human immunodeficiency virus was present in society during that period. There was no iatrogenic epidemic of endoscopically induced illness. Therefore, a natural experiment has occurred.

Data on the viability of these viral particles exist. Generally, glutaraldehyde is virucidal with a soak time of one to two minutes. The Centers for Disease Control (CDC) guidelines (10-minute soak time, etc), which are frequently cited (as by Katner et al), are written by a microbiologist citing indirect data based on respiratory equipment studies. These soak times have been extrapolated with a subjectively determined margin of safety. More recently, several authorities have cited disinfection soak times of 2 to 4 minutes.^{2,3} Thus, the CDC guidelines are acknowledged as authoritative, but others have taken informed exception to them.

The most important message is that flexible sigmoidoscopy and colonoscopy in the family physician's office is a safe and effective method for the

early detection and prevention of colorectal cancer. While there is the potential risk of iatrogenic infection, these cases are so rare that the finding of one case merits publication.

In summary, the article by Katner et al is timely and important. Nevertheless, by citing the 10-minute soak time as a gold standard, there may be a slight inflation as to the prevalence of the problem. While advocating close attention to this aspect of endoscopic care, we would respectfully point out that the "maximin" approach to clinical care has serious environmental implications for our specialty and the profession.⁴

For our annual presentations at the AAFP Scientific Assembly, we review the world's literature as a faculty group. We continue to feel that manufacturers and many colleagues use the maximin strategy in overdramatizing risk with a presentation of catastrophic expectations. There are epidemiologic data and microbiological data that suggest shorter soak times are safe and effective. A more thorough exposition of these data is available in our most recent syllabus.⁵

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