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.

PROSTAGLANDIN AND INDUCTION OF LABOR

To the Editor:

Clarification is needed for those wishing to use prostaglandin E_2 in a clinical or research setting as described by Smith et al (*Smith MA, Swan L, Caruthers BS, Heaton C: Outpatient use of prostaglandin gel for ripening of the cervix and induction of labor. J Fam Pract 1990; 30: 656–664*). What was the usual dose of prostaglandin administered? It appears that 5-mL syringes containing 2 mg of prostaglandin were used. However, in the "recipe" described ("grinding a whole 20-mg suppository . . . and mixing it with 100 mL of sodium carboxymethylcellulose 2% gel), the concentration of prostaglandin would only be about 0.2 mg/mL or 1 mg/5-mL syringe.

Both dosage levels may be safe, but for comparisons with other studies, it is essential that this information be clearly stated.

John V. Jurica, MD
Kankakee Family Medicine
Kankakee, Illinois

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

A clarification was requested on the preparation of the prostaglandin E_2 gel used in our study. While it is correctly stated that the dose per gel was 2 mg/5 mL, the description of the gel preparation should have stated that two whole 200-mg suppositories are mixed with 100 mL of sodium carboxymethylcellulose 2% gel. The authors also appreciate and endorse the Commentary by Dr Steven Eisinger that accompanied our paper, and his cautionary note to physicians regarding the nonapproved status of prostaglandin gel for cervical ripening. Patients should be so informed and further studies should be encouraged so that the safety and efficacy for both inpatient and outpatient use can be determined.

Mindy Smith, MD, MS
Barbara Caruthers, MD
Lynn Swan, MD
Caryl Heaton, DO
Department of Family Practice
University of Michigan
Medical Center
Ann Arbor

To the Editor:

The series reported by Smith et al on outpatient use of prostaglandin gel in the June issue of the Journal was of great interest.[1] However, Dr Eisinger's commentary merits a response. He makes the appropriate point that additional larger studies of prostaglandin gel for ripening the cervix need to be conducted, and he goes on to suggest breast stimulation and laminaria as "nonpharmacologic" alternatives in the interim. He further comments that "safety, although always an issue, appears to be good" and suggests that breast stimulation can be applied by the patient at home.

A search of AMANET using key words "nipple stimulation" revealed 15 articles, four of which detailed serious or potentially serious problems with nipple stimulation. One of the articles described a case of placental abruption,[2] and the other three articles described hyperstimulation.[3-5] Hill et al found that hyperstimulation was present in 45% of patients and noted that 21% of these had significant fetal bradycardia. His group concluded that "there is a relatively high incidence of exaggerated uterine activity in response to the breast stimulation stress test and close surveillance of mother and fetus are warranted during antepartum nipple stimulation."[5]

These studies would cast some

doubt on safety of breast stimulation performed at home in an attempt to ripen the cervix, although undoubtedly couples have been doing it for centuries before the issue of the unripe cervix ever arose. Laminaria, although nonpharmacologic, are certainly not what our patients would describe as noninvasive.

On the basis of the case series of Smith et al, as well as other reports in the literature, prostaglandin gel instilled in a hospital setting with monitoring for perhaps 1 hour after application certainly seems an appropriate choice for the physician who is wondering what to do until trials comparing the various methods can be carried out.

Owen Panner, Jr., MD
Alturas, California

References

1. Smith MA, Swan L, Caruthers BS, Heaton C: Outpatient use of prostaglandin gel for ripening the cervix and induction of labor. J Fam Pract 1990; 30:656–664
2. Taylor RN, Green JR: Abruptio placentae following nipple stimulation. Am J Perinatol 1987; 4:94–97
3. Keegan KA, Helm DA, Porto M, et al: A prospective evaluation of nipple stimulation techniques for contraction stress testing. Am J Obstet Gynecol 1987; 157:121–125
4. Schellpfeffer MA, Hoyle D, Johnson JWC: Antepartal uterine hypercontractility secondary to nipple stimulation. Obstet Gynecol 1985; 65:588–591
5. Hill WC, Moenning RK, Katz M, Kitzmiller JL: Characteristics of uterine activity during the breast stimulation test. Obstet Gynecol 1984; 64:489–492

AMNIOTOMY AND DURATION OF LABOR

To the Editor:

In his study on amniotomy,[1] Dr Franks states that there has been only one previous randomized trial[2] examining the effect of amniotomy on the length of labor. Wetrich,[3] however, conducted a randomized study in which he compared amniotomy with no amniotomy during labor at 6-cm dilatation. Patients whose membranes were ruptured had a 60-minute average shortening of their remaining first stage of labor. Dr Franks showed a 155-minute shortening, but he measured from randomization to delivery, and the amniotomy was done earlier (3- to 6-cm dilatation).

Areas of further study might include the effect of amniotomy before 3-cm dilatation both in labor and not in labor. Also, in Dr Franks' study it would be helpful to know whether the membranes were ruptured in the active or latent phase of labor. This information could be determined retrospectively by examining the Freidman labor curves.

John W. Ely, MD
Columbia, Missouri

References

1. Franks P: A randomized trial of amniotomy in active labor. J Fam Pract 1990; 30:49–52
2. Stewart P, Kennedy JH, Calder AA: Spontaneous labor: When should the membranes be ruptured? Br J Obstet Gynaecol 1982; 89:39–43
3. Wetrich DW: Effect of amniotomy upon labor: A controlled study. Obstet Gynecol 1970; 35:800–806

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

I am grateful to Dr Ely for pointing out an additional randomized study examining the effect of amniotomy on labor. The omission resulted from my enclosure in the time capsule imposed by computerized literature searches. Regarding his additional points: amniotomy has been found to be more efficacious than oxytocin in labor induction[1]; and we are unable to examine the modifying effect of the phase of labor on amniotomy since we do not construct labor curves.

Peter Franks, MD
The Family Medicine Center
University of Rochester
New York

Reference

1. Bakos O, Backsrom T: Induction of labor: A prospective, randomized study into amniotomy and oxytocin as induction methods in a total unselected population. *Acta Obstet Gynecol Scand* 1987; 66:537–541

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USE OF DRUG LISTS

To the Editor:

The enclosed form (Figures 1 and 2) has been developed to meet a severe problem (heretofore not encountered) by this ex-academic, ex-multispecialty group, ex-HMO, board-certified family physician, now in the jungle of fee-for-service medicine.

Upon my husband's retirement from Rush Medical School, we sought semiretirement in a rural paractice that had lost its young National Health Service physician and no longer was able to survive financially with only a family nurse practitioner.

We are on the edge of two rural counties with respective hospitals more than 30 miles each way, and yet a third county hospital (university afilliated) is in a small city 35 miles in a third direction. A large retired urban and retired military population is settling here. The VA hospitals, 200 miles away, add to the confusion.

While I was associated with the health maintenance organization, I had control of referrals and shared charts. Here, it is not unusual to have a patient come to our little clinic with a bag holding 20 to 30 bottles of medicines. There are no multispecialty groups, and a family physician must juggle the prescribing prejudices of five or six secondary and tertiary physicians who have referred among each other with no "managing physician." To retain my sanity, I made drug lists for these patients.

A drug list has surprised some of the invasive cardiologists, rheumatologists, and gastroenterologists by making clear the prescribing conflicts that abound. It has saved me from trying to contradict the "important specialists." Several have been relieved to see that there is a family physician who will manage the whole patient.

A lot of dangerous and unnecessary drugs have been stopped by the physician who long ago initiated the therapy by telling the patient, "This drug is never to be stopped." No colleagues have been offended.

I would expect that other primary

DOCTORS PHONE NUMBERS

Penslow 919-329-7591

Maple Hill 919-259-6444

NURSING SERVICE PHONE

PHARMACY PHONE NUMBERS

Penslow 919-329-6151

KNOWN DRUG ALLERGY

Questions to ask next visit:

Patient's Name: _____

Birthday: ___/___/___

Phone: (___) _____

MEDICATIONS LIST

CARRY TO ALL DOCTORS AND PHARMACIES

PENSLOW MEDICAL CENTER
HOLLY RIDGE
US 17 at NC 50
DYSON STREET

329-7591

Figure 1. Medications List—front.

Patient's Name: _____ Updated: _____

Rx Date Doctor	TRADE NAME	Strength	CHEMICAL (Generic) NAME	HOW TO TAKE	WHAT FOR?	CAUTIONS

(Non-Prescription) DRUGSTORE ITEMS

ALCOHOLIC BEVERAGES

Figure 2. Medications List—back.

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care physicians would also find this approach useful in their practices.

Charlotte Levine, MD
Penslow Medical Center
Holly Ridge, NC

FAMILY FOLDERS

To the Editor:

Concerning the article "Is It Worthwhile to File by Family Folders in Family Practice?" (*Farley ES: An affirmative view. Schneeweiss R: An opposing view. J Fam Pract 1990; 30:697–703*) by Farley and Schneeweiss, I have written to you about this before, and I will say it again: I have been teaching family medicine residents for nearly 20 years, and every single physician who has practiced with me for periods of 2 to 6 weeks has been both intrigued and sometimes even excited by our family filing system. Some who have gone on to group practices have changed the filing systems there, and their colleagues have agreed that it is superior to file by family. Forgetting all the philosophical and pedagogical arguments, family physicians should file by family for several important reasons:

It is simpler.
It is faster.
It is cheaper.
It is more convenient.
It takes less space.

There are over 5000 patients in this solo practice and there is no way I shall ever again file by individual patient. Unless someone has personally worked with both systems, he should restrain his comments, intellectualism and logic notwithstanding.

There is a rejoinder: It is difficult to file by family in an institutional setting. The true efficacy of the system manifests itself best in small group or solo practices. We tried (heroically) in Harvard's family medicine program some 20 years ago, but it was too cumbersome in spite of a relatively small group (five family physicians) and adequate secretarial help.

As for Dr Schneeweiss's comments about the Society of the Teachers of Family Medicine Records Committee and family medicine textbooks not recommending filing by family, a good portion of these physicians are institutionally based and their preferences are thus institutional. I believe it is imperative that we teach residents the organizational strength of filing by family. That is very difficult to do in a teaching hospital, where filing by individuals is more efficacious.

A dilemma.

Eugene Guazzo, MD
Maryland Infirmary
Chaptico, Maryland

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

I appreciate the comments made by Dr Guazzo and am impressed with his conviction that for him as a solo practitioner filing by family folders is the only way to file his patients' records. I do wonder whether his assertion that family filing is simpler, faster, cheaper, more convenient, and takes less space would hold up to close scrutiny.

As one who has indeed used both systems extensively, I would be hard pressed to back up the above assertions with facts. It may be that it is impossible to prove them, and physician satisfaction is the only measure of the value of family filing—but even that has not yet been studied. Certainly there are no published articles that I am aware of that support the idea that family filing is simpler, faster, cheaper, more convenient, and takes less time. I would encourage those of my colleagues who have the interest in the topic to demonstrate those assertions to be true.

We should be willing to subject all our cherished beliefs to the test of objective study and live with the results. I agree with Dr Guazzo that in the residency the difficulties of setting up filing by families is compounded and may be impractical. That was certainly our experience at the University of Washington.

I would be less sanguine than Dr Guazzo about discounting the absence of any mention about family filing by the STFM Records Committee. We have to ask why it is that the idea of filing by families has not yet captured the imagination and commitment of our colleagues.

A dilemma indeed.

Ronald Schneeweiss, MD
Department of Family Medicine
University of Washington
Seattle

To the Editor:

I was horrified to learn of the large number of family practice residencies that do not file charts in family folders. Of course, I realize that many physicians do not use genograms on a regular basis (unfortunately), but having all household charts in a simple folder provides very important opportunities for preventive care (not to mention preventing the physician from appearing foolish by forgetting important information about the family group). Well-child care provides me with the perfect setting in which to check on the parents' contraceptive choices and how they are working out. I find this particularly important for teenage mothers in whom the rate of repeat early pregnancies is unacceptably high. Numerous other examples of "windows of opportunity" spring to mind.

"True worth is in being" . . . but I don't see how we can "be" attentive to the family without a tool as basic as family charting.

Ann Reichsman, MD
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