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. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication.

CLINICAL RELEVANCE

To the Editor:

It is with great satisfaction that I write this letter since for many years I have been critical of the Journal for its lack of clinical relevance in many of its articles.

Over the last few months there has been a significant change in the Journal as exemplified by the article by Toffler and colleagues (*Toffler WL, Olenick JS, Wolf NE, et al. The immunogenicity and safety of intradermal hepatitis B vaccine. J Fam Pract 1991; 33:149–54*), where we see family physicians engaged in original clinical research that furthers our understanding of clinical practice and contributes important new information regarding preventive approaches to disease. It is just this kind of clinical research that will carve a legitimate research niche for our specialty and make it easier for the rest of us to continue in our research endeavors.

My sincere congratulations to the authors and the editors who have seen fit to guide the Journal in new and exciting directions.

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EFFICIENT DIAGNOSIS

To the Editor:

In their recent article, Drs Seller and Lobley[1] comment that "cross-cultural comparisons [of medical care] are difficult to perform and interpret." I would agree with this statement, but even more important, I would agree with something else implied by the article: we can learn a lot about medical care in this country by studying health care in other countries.

As they acknowledge, their study has many methodologic difficulties, including noncomparability of sampling techniques. In addition, since case selection involved backward tracing from diagnoses to presenting symptoms, the results are probably not an exact reflection of the diagnostic process that occurs in primary care. Their results tell us nothing about the relative cost-effectiveness of the evaluation of patients whose presenting symptoms are not associated with serious diagnoses. What is needed next is a prospective international study of *presenting complaints*.

An important issue that was not addressed in their discussion is that diagnostic interval is only one part of the equation that links onset of patient symptoms with diagnosis, treatment, and outcome. For example, in a study of American patients with colorectal cancer, the time interval between first clinic visit and definitive surgical therapy for health maintenance organization (HMO) patients was three times greater than that for fee-for-service (FFS) patients (47 days vs 14 days).[2] However, the time interval between onset of first symptoms and initiation of first clinical contact by patients with a variety of cancers was greater for FFS patients than for HMO patients (38 days vs 25 days) from the same practices.[3] Time interval from first symptoms to diagnosis and treatment would seem to be a key variable that should be included in future international comparison studies.

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2. Francis AM, Polissar L, Lorenz AB. Care of patients with colorectal cancer: a comparison of a health maintenance organization and fee-for-service practices. Med Care 1984; 22:418–29.
3. Greenwald HP. HMO membership, co-payment, and initiation of care for cancer: a study of working adults. Am J Public Health 1987; 77:461–66.

DIABETES SCREENING

To the Editor:

The study by Worrall (*Worrall G. Screening healthy people for diabetes: is it worthwhile? J Fam Pract 1991; 33:155–60*) was interesting. I am not sure it was legitimate to use the National Diabetes Data Group plasma glucose level (140.5 mg/dL) on capillary whole blood. Whole blood glucose levels are generally 10% to 15% lower than plasma blood values. I think it would have been more appropriate to use 120 mg/dL (whole blood) as the cutoff for screening. Anyone with a value over that level should have had a serum value determined (140 mg/dL cutoff). Patients in this study who had a capillary reading between 120 and 140 mg/dL (plasma values possibly 140 to 160 mg/dL) were probably missed. Thus, a not-too-sensitive test became even less sensitive. This study probably has a very high false-negative rate, which, of course, could explain the low prevalence rate found in Worrall's sampled cohort.

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ANDROSCOPY

To the Editor:

I am writing in reference to the article by Wm. Jackson Epperson on androscopy[1] and the accompanying editorial by Drs Patton and Rodney.[2]

I want to commend Dr Epperson on a very comprehensive study and a well-written article. The major point he emphasizes is the patient

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education value of androscopy.

Family physicians see young female patients at the time of their sports physicals, pre–high-school examinations, etc. These are opportune times to discuss that limiting the number of sexual partners and being monogamous may be the best approach to avoiding cervical cancer. Family physicians also see young male patients. It must be impressed upon them that they can become vectors of the disease. In their editorial, Patton and Rodney state that androscopy is of unproven benefit. I would have to strongly agree with them in an *academic sense*. However, the alternative that I see practiced now is that little or no education is given to men. Men, especially young ones, do not want to go into a gynecologist's office and sit with a room full of pregnant women to hear a rushed 5-minute discussion about human papillomavirus (HPV). Subsequently, girlfriends or wives are asked to relay pertinent prevention information. This is often done in a poor fashion.

If we really are sincere that we, as family physicians, want to prevent disease, then a half-hour visit is not too long to spend with a man who has been exposed to HPV or who has genital lesions. Perhaps the full androscopy examination is not necessary. However, I strongly believe that the office visit and time for discussion is imperative.

Although Patton and Rodney state that "to date, no link with HPV has been demonstrated" with penile cancer, a recent study from China showed a high association of genital warts on physical examination among patients with penile cancer.[3] Another study by Boon concerning penile cancer stated that "it is clear that Balinese men are both vectors and victims of HPV."[4] The association of human papillomavirus with anal cancer has also been documented in several studies.[5–7] Even if penile cancer rates are low, men should be advised to report any nonhealing lesions to their physician.

Unfortunately, we do not have all of the answers yet. Prudent medicine at this time, however, would dictate counseling for every male patient who has an HPV infection or has been exposed to HPV. Even if there were no risk factors for men, they must be informed that their partners must have regular Papanicolaou smears if not colposcopic examinations. Men spread the disease. The scientific, academic proof is not there that treating and resolving the warts makes the situation better. Nor is there scientific proof that patient education in this field works (yet). But do we just bury our heads in the sand and ignore the issues? The major emphasis with androscopy should be education!

John L. Pfenninger, MD
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tion among homosexual males with group IV HIV disease. JAMA 1990; 263: 2911–6.
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7. Gal AA, Saul SH, Stoler MH. In situ hybridization analysis of human papillomavirus and anal squamous cell carcinoma. Mod Pathol 1989; 2:440–3.

The preceding letter was referred to Drs Epperson, Patton, and Rodney; Dr Epperson responds as follows:

I greatly appreciate the interest and comments of such an outstanding leader in family medicine as Dr Pfenninger.

The most cost-effective indications for androscopy are as yet unknown. I am in the process of contacting several international experts in this area in an attempt to come up with a practical consensus on the use of androscopy. My feelings are that androscopy is an excellent tool for primary care physicians to use in the diagnosis of male anogenital human papillomavirus (HPV). Once diagnosed, the methods of preventing further spread to women can be discussed with the patient. Without the documentation of this disease through androscopy, the patient will never be fully informed about his disease process.

As Dr Pfenninger reports, the incidence of high-grade penile intraepithelial neoplasia is low, but important. Campion et al[1] found a very high incidence of high-grade penile intraepithelial neoplasia (PIN) in the male sexual contacts of women with high-grade cervical intraepithelial neoplasia (CIN). Carcinoma in situ of the penis was also found in this study of 50 patients. As the incidence of HPV infection continues to grow, we may find that the rare incidence of PIN becomes more prevalent. We will not know this without the use of androscopy. Physicians cannot overlook the importance of screening men at high-risk for PIN just because their personal experiences have found dysplasias to be rare in their patient populations. Medical literature supports this point in numerous substantial studies.

Our practice of medicine frequently involves the use of commonsense medical advice. Often there is little or no published information available in the academic medical literature to support it. Until there are publications available to answer our questions, we must seek out methods of care based on sound medical judgment. In my opinion, it is sound medical practice to identify an infectious disease and try to prevent its spread through comprehensive patient education.

There is no vaccine available for the prevention of HPV, and there is little chance that this will become available in the near future. Prevention is our only means of reducing the spread of this disease. Men with anogenital HPV must be made aware of their contribution to the spread of this cancer-causing virus. Our present methods of patient education have failed to control the HPV epidemic. Androscopy provides a significant tool for the identification and patient education of men exposed to HPV. More primary care physicians need to provide this procedure for their patients.

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1. Campion MJ, McCance DJ, Mitchell HS, Jenkins D, Singer A, Oriel JD. Subclinical penile human papillomavirus infection and dysplasia in consorts of women with cervical neoplasia. Genitourin Med 1988; 64: 94–9.

Dr Patton responds to Dr Pfenninger as follows:

Dr Pfenninger has long been an advocate of patient education. We admire this and could not agree more with his concern that young men need to know that they can be the vector of a disease that may be associated with an increased probability of cervical cancer. At this time HPV is not known to cause cancer. This distinction is important.

We agree that devoting 30 minutes to that task is reasonable. We do have some concern about using androscopy to accomplish patient education, believing that it may send a false message, a message that suggests there is an effective medical intervention that can cure a person of the HPV infection.

The HPV-penile cancer link remains questionable. Most of the articles cited by Dr Pfenninger were from selected populations. The articles also presented several confounding factors that make it impossible to assume any cause-and-effect relationship between HPV infection and penile cancer. These factors include race, hygiene, phimosis, sex outside of marriage, and human immunodeficiency virus infection. The science, however, does not preclude such a link being established in the future. If it is established, and if the incidence of cancer of the penis increases to a point that it warrants some form of screening test, an appropriate screening test will need to be identified that will be applicable to large populations, will be cost-effective, and will allow intervention at a stage that will preclude the use of therapies that may severely handicap the person. At this time, when there is (1) no effective treatment for HPV infection, (2) no established link between HPV infection and cancer of the penis, and (3) no evidence suggesting an increasing incidence of cancer of the penis in our population, the use of androscopy to decrease the incidence of carcinoma of the penis or to diagnose carcinoma of the penis at its earliest stages is unwarranted. We, therefore, agree with Dr Pfenninger that education that focuses on ways of decreasing or eliminating transmission of HPV and other pathogens is, and always will be, an important task for all physicians, and especially family physicians.

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