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. Send letters to Paul M. Fischer, Editor, The Journal of Family Practice, Department of Family Medicine, Medical College of Georgia, Augusta, GA 30912, or Fax (706) 855-1107.

MEDIPLAN ACT

To the Editor:

The President will soon present his plan to reform our health care system and Congress will begin intensive consideration of various health reform proposals. I would like to call your attention to a major reform option that (1) is easy to understand, (2) Congress can pass, and (3) avoids many of the political problems caused by other plans. That option is Medicare for everyone.

Recently, I introduced the Mediplan Act of 1993 (H.R. 2610), which would expand the Medicare program to cover everyone. Medicare is the effective and efficient "made in America" health insurance system that takes care of our senior citizens.

Benefits under Mediplan would be enhanced to include out-of-pocket limits and a prescription drug benefit. Mediplan also would guarantee coverage to low-income individuals and children.

Mediplan is designed to be budget neutral. It would be financed with an average monthly premium of $125 per person, which would be collected through the income tax system. Employers would pay 80% of the premium through a payroll tax of about 60 cents per hour (employees would pay 15 cents). In addition, there would be a 10% excise tax on providers to finance the coverage of low-income individuals and the uninsured—which would help to alleviate the rampant current practice of cost-shifting to cover these individuals.

I am convinced that Mediplan will help meet the challenge of providing equal access to quality health care for everyone. In addition, it would allow freedom of choice in selecting providers, and the coverage would be completely portable.

Mediplan is cost-effective. It utilizes the framework and cost-containment devices of a proven, successful program. Unlike other proposals, it offers major reform with minimum disruption to people's existing ways of getting health care. It is an easy concept to grasp. Once the public better understands the various options, Mediplan is likely to be one Congress actually can pass.

As you comment on health reform, I hope you will consider this option.

Pete Stark
Member of Congress
Thirteenth District, California

INSOMNIA

To the Editor:

Dr Rakel's discussion of a common patient complaint is particularly germane to physicians caring for an increasingly aging population.[1] While the ineffectiveness of benzodiazepines in the patient with chronic insomnia is discussed briefly, it should be noted that 11% of insomniacs receiving medication are nightly users.[2]

Although the adverse effects of benzodiazepines (eg, hangover, impaired mentation and performance, increase in falls and fractures) are infrequent, the manifestation of them may be occult to the clinician and patient until an accident occurs. If compared with the benefits, the relative importance of these side effects achieves even greater impact. All patients (acute and chronic insomniacs) for whom hypnotics are prescribed should be clearly informed about these risks.

The scientific support of the statement "hypnotics will break the cycle of sleeplessness" is not discussed in the article. Therefore, the statement that combines the assurance of patient safety with effectiveness ("Hypnotics are safe medications that can effectively break a debilitating cycle of sleeplessness") exceeds my level of confidence in these drugs.

Most troubling is the implication that because drowsiness or fatigue is a significant cause of accidents in the United States, and because insomnia causes drowsiness, then insomnia is a causality for accidents. This is difficult for me to accept given the evidence. If I try to drive very far at 3:00 in the afternoon, I get very sleepy, whether I have slept 4 or 10 hours the night before. In fact, I am concerned (though I have no proof) that a treatment for insomnia (hypnotics) may result in an increased rate of accidents.

Ronald J. Hicks, MD
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References

1. Rakel R. Insomnia: concerns of the family physician. J Fam Pract 1993; 36:551–8.
2. Gillin JC, Byerley WF. Diagnosis and management of insomnia. N Engl J Med 1990; 322:239–48.

The preceding letter was referred to Dr Rakel, who declined to respond.

CERVICOGRAPHY

To the Editor:

In their article on cervicography *(Ferris DG, Payne P, Frisch LE, Milner FH, diPaola FM, Petry LJ. Cervicography: adjunctive cervical cancer screening by primary care clinicians. J Fam Pract 1993; 37:158–64)*, Dr Ferris and colleagues reported a twofold increase in detection of premalignant disease using cervicography and Papanicolaou (Pap) smear compared with Pap smear alone. Unfortunately, they failed to compare a third category using visual inspection of the cervix after application of vinegar without cervicography.

For the past 2 years I have been routinely applying vinegar to the cervix before obtaining Pap smears. It is not uncommon to find acetowhite lesions and normal Pap smears even when the acetowhite area is specifically sampled and labeled for the pathologist. At colposcopy, these areas are confirmed to be dysplastic, though a colposcopically directed Pap smear may again fail to identify any abnormality.

Applying vinegar before obtaining the Pap smear adds negligible cost, takes very little time, and is often a useful way to remove excess mucus. It does not interfere with the cytopathologist's ability to interpret the Pap smear and requires very little training for the primary care physician. Before we suggest a new and expensive technique, let us first see if it is better than what we already have.

Stuart H. Freedenfeld, MD
Stockton Family Practice
Stockton, New Jersey

The preceding letter was referred to Drs Ferris and Frisch, who respond as follows:

The relative insensitivity of the Papanicolaou smear, as noted by Dr Freedenfeld, is of concern to all clinicians. Thus, the reason for the development of adjunctive tests such as acetic acid wash, speculoscopy, cervicography, HPV-DNA testing, and screening colposcopy becomes clear. Other tests under evaluation include laser-induced fluorescent spectroscopy, chromocolposcopic imaging with AZEA trichromic stain, and the Polar probe from Australia. We applaud Dr Freedenfeld's efforts to seek ways to improve the performance of cervical cytology.

In the referenced article,[1] we successfully evaluated cervicography as an adjunctive test in primary care clinics. We also examined naked-eye inspection of the cervix after acetic acid application, and have reported the results of this part of the study separately.[2] The reported greater than twofold increase in disease detection with cervicography[1] compared quite favorably with the 30% previously reported for acetic acid wash.[3] Furthermore, the false-positive rate of 26% in the cervicography study was approximately half of the 48% false-positive rate reported for acetic acid wash.[3]

The difference in outcomes between acetic acid wash and cervicography may be explained by image magnification and consideration of multiple colposcopic signs indicative of cervical disease. Acetic acid wash is limited to a single colposcopic sign of acetowhite epithelium, which may or may not indicate disease. It would appear, based on available studies, that the single sign is predictive of disease for only 50% to 65% of patients. The predictive accuracy for cervical disease improves by considering other colposcopic signs such as the lesion margin, true color, blood vessel appearance, contour, and reaction to iodine staining. The addition of an acetic acid wash will detect more disease. However, if one of every two women with a positive acetic acid wash test is inappropriately referred for colposcopic evaluation, the seemingly inexpensive test becomes quite expensive and time intensive for the patient free of disease. Effective cervical cancer screening tests not only detect true premalignant precursors but also limit referrals of women with normal anatomy.

The application of acetic acid to the cervix, or for that matter any other solution or substance, before cervical cytologic sampling is generally discouraged. The weak acetic acid may produce intracellular dehydration and thus adversely affect normal cellular morphology. Also, the acetic acid wash will do precisely that, decrease the cellular yield from the ectocervix. In appreciation of Dr Freedenfeld's experience with this technique, and perhaps given the opportunity to dispel a myth of medicine, we evaluated cervical cytology collected both before and after acetic acid wash in one patient. To our surprise, other than a significantly reduced cellular yield, the squamous cells were not significantly distorted. Dr Freedenfeld's technique, therefore, deserves further controlled evaluation.

Finally, we have not suggested a new technique but merely have reported our observations about a screening tool that has existed for 10 years. We thought this contribution to scientific knowledge based on the experiences of primary care clinicians might be important when considering the many available options for adjuvant cervical screening.

Daron G. Ferris, MD
Lawrence E. Frisch, MD
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References

1. Ferris DG, Payne P, Frisch LE, Milner FH, diPaola FM, Petry LJ. Cervicography: adjunctive cervical cancer screening by primary care clinicians. J Fam Pract 1993; 37:158–64.
2. Frisch LE, Milner FH, Ferris DG. Naked-eye inspection of the cervix after acetic acid application may improve the predictive value of negative cervical cytology. In press.
3. Slawson DC, Bennett JH, Herman JM. Are Papanicolaou smears enough? Acetic acid washes of the cervix as adjunctive therapy: a HARNET study. J Fam Pract 1992; 35:271–7.

PATIENT EXPECTATIONS

To the Editor:

I would like to respond to the article on parental expectations by Drs Daniel C. Vinson and Lawrence J. Lutz *(Vinson DC, Lutz LJ. The effect of parental expectations on treatment of children with a cough: a report from ASPN. J Fam Pract 1993; 37:23–7).*

Fresh out of residency, I offered to meet a patient in the emergency department at 10 PM to evaluate his "terrible sore throat." When a rapid strep test was negative, I spent a futile 15 minutes explaining why he didn't need antibiotics. I ultimately left him to see the ER physician, who we both knew would most likely prescribe an antibiotic for him.

As I emerged from the room, I ran into the director of my former program. After hearing my story, he commented, "Some patients pay you for your advice, and some patients pay you to write an antibiotic prescription. You have to decide if you want that business."

I decided that if I didn't write antibiotic prescriptions, someone else would. Looking at it this way, I don't get into fights anymore with patients. If a patient with an upper respiratory tract infection wants my advice, I give them an accurate diagnosis and a list of over-the-counter medications for symptomatic care. If they want a prescription, they may get one—for their "bronchitis," or "possible strep," or "early sinusitis."

Gilbert L. Solomon, MD
Canoga Park, California

The preceding letter was referred to Drs Vinson and Lutz, who respond as follows:

We have been in the situation that Dr Solomon describes and know the discomfort of being coerced to order inappropriate tests or prescribe unnecessary medications. Dealing with a patient's importunity requires patience and skill, and the development of a trusting relationship over time.

Our study, however, did not address the issue of obviously inappropriate patient requests, as important as it is. We addressed rather the issue of uncertainty, the gray zone where a clinician frankly doesn't know whether an antibiotic will be helpful for the patient. Our study found evidence that clinicians allow parental expectations to influence their diagnosis and treatment, and we believe that influence operates primarily in the gray zone of clinical uncertainty. Dr Solomon's assessment, that our findings provide evidence of physicians' acquiescing to unreasonable parental demands, is an equally valid interpretation of our data; but based on our own clinical experience and our assessment of ASPN practitioners' clinical skills, we expect that inappropriate acquiescence accounts for a minority of the instances of parental influence that we found.

A more fundamental issue is whether patient or parental expectations should influence clinical decisions. Given the uncertainties in medical decision-making, we believe they should. The issue is important, and worthy of further study.

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Lawrence J. Lutz, MD
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Columbia

ENDOMETRIOSIS

To the Editor:

As a family physician who is the medical director of a small independent practice association (IPA) with all capitated HMO patients, I have become very concerned with the technological imperative and expense involved in the evaluation and treatment of endometriosis, namely an unrestrained rush toward laparoscopy and Lupron (TAP Pharmaceuticals, Deerfield, Ill). I was thus disappointed to read Dr Damewood's otherwise comprehensive clinical review on endometriosis *(Damewood MD. Pathophysiology and management of endometriosis. J Fam Pract 1993; 37:68–75)*. The author provided no sophisticated discussion of the difficult problems of practical noninvasive evaluation of pelvic pain, the possibilities of using medications before laparoscopy, or the nature of the clinical skills and judgments needed to avoid laparoscopy if possible. Must all young women with pelvic pain undergo laparoscopy? (Not every patient with heartburn requires an upper GI endoscopy.) Perhaps the author could give some wise advice on these practical considerations.

Jeoffry B. Gordon, MD, MPH
San Diego, California

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

The letter from Dr Gordon raises important considerations with respect to endometriosis and pelvic pain, particularly in young women. Certainly not all young women with pelvic pain need to undergo laparoscopy. In many situations, a trial of oral contraceptives to stop ongoing dysmenorrhea may be considered before any invasive procedures. In addition, extensive therapy with nonsteroidal anti-inflammatory medications such as Anaprox or Motrin may also be instituted before invasive surgical procedures. However, the diagnosis of endometriosis can only be made by laparoscopy. Therefore, if the pelvic pain persists despite nonsurgical intervention, a diagnostic procedure should be considered.

Medical management does remain important in the management of endometriosis-associated pelvic pain, which is often a difficult and recurrent problem, particularly in young women. These young women have had good results with uninterrupted oral contraceptives, where these patients have had no menstrual cycles for 3 to 6 months. This may also be attempted before surgical intervention or Lupron (TAP Pharmaceuticals, Deering, Ill.) therapy. Again, it is often difficult to differentiate between primary dysmenorrhea and endometriosis. If medical therapy fails, then a laparoscopy is indicated.

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