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, 519 Pleasant Home Rd, Suite A-3, Augusta, GA 30907-3500, or Fax (706) 855-1107.

PSYCHIATRIC INTERVIEW

To the Editor:

I found the patient history interview proposed in the article by Dr Zimmerman[1] to be an excellent review of psychiatric illness but suboptimal for primary care because of its inadequacy as a screen for depressive illness. It is well established that, while many patients with psychiatric illness present to the primary care physician, most of these illnesses are depressive or anxiety disorders with prominent somatization.[2] Dr Zimmerman's interview omitted the typical symptoms of these conditions.

I have personally found the following series of questions to be helpful:

> Do you have any difficulty sleeping? *(obtain details)*
> Has your weight changed recently? *(obtain details)*
> Do you have heart-racing or palpitations?
> Are you under stress or "stressed-out"?
> Have you ever experienced verbal, sexual, or physical abuse or other major traumas?

These questions have been quite fruitful in assessing the possibility of psychiatric disorders in my patients. Because of the stigma associated with psychiatric diagnoses and the milieu chosen by the patient for seeking care (the primary care setting), I sometimes delay asking the last question listed and further assessing other psychiatric symptoms until a later visit when an effective rapport has been established with the patient.

According to Kanton and colleagues,[2] the psychiatric patient presenting to the primary care physician usually focuses on somatic complaints. Not only will the psychiatric orientation of Dr Zimmerman's interview miss the majority of such patients, but its relentless questioning about behaviors that will be considered aberrant by most patients may actually lessen their willingness to accept a psychiatric diagnosis.

M.L. Elks, MD, PhD
Department of Internal Medicine
Texas Tech University
Health Sciences Center
Lubbock, Texas

References

1. Zimmerman M. A five-minute psychiatric screening interview. J Fam Pract 1993; 37:479–82.
2. Katon W, Kleinman A, Rosen G. Depression and somatization: a review. Am J Med 1982; 72:127–35, 241–7.

IMPORTANCE OF LISTENING

To the Editor:

I thoroughly enjoyed Dr Miller's editorial in your publication (*Miller WL. Physicians, patients, and third parties: everybody's talking but is anybody listening? J Fam Pract 1993; 37:331–3.*). He eloquently captures the dilemma of the demands of time, patients, and outside regulation on the family physician. He also acknowledges that we have been part of the problem.

I agree wholeheartedly with his statement, "Academicians must learn to implement their lofty ideals within the pragmatics of everyday practice." As a third-year resident with 5 years' general practice experience, I have repeatedly been dismayed by our self-flagellation over the things we don't do but feel we "must" do. Too little is said of the great strides we have made in bettering the lives and health of our patients.

This problem was driven home rather poignantly in a recent conversation I had with one of our first-year residents during an on-call night. He clearly felt overwhelmed and was having second thoughts about his career choice in family practice. He wondered aloud whether he was capable of establishing rapport, performing all the required health maintenance, immunization update, sexual history, drug and alcohol history, screening for depression, sexual abuse, physical abuse, and domestic violence, and dealing with end-of-life issues, not to mention addressing the reason the patient came to see him! Aren't all of these required to be a "good" physician? He could not imagine how an office visit could ever take less than an hour!

We need a reasonable perspective on important screening issues. Yes, they are important, but they are not of immediate importance in every patient. They are issues of which we should be aware, just as we are aware of how to perform a complete neurologic examination. Both can be implemented when appropriate but need not be done for every patient. Equating lack of performance of all of these recommendations with substandard "doctoring" will make family practice that much more difficult to "sell" to prospective students and residents. These are skills to be learned, but as Dr Miller so aptly states, ". . . the importance of intuition, continuity of care, and the process of distinguishing between various types of visits . . ." should not be overlooked.

Wayne S. Strouse, MD
Gray, Tennessee

UMBILICAL 'STONES'

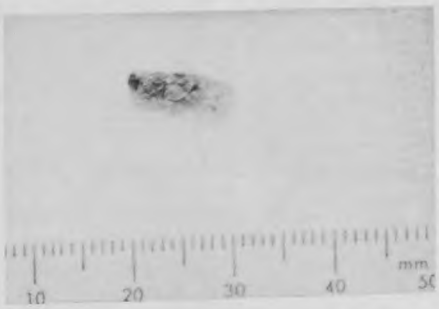
To the Editor:

There have been very few reports in the literature of patients presenting with a "stone" impacted in the umbilicus, and those I have found present asymptomatic cases.[1,2] I now report on two such cases where the masses caused symptoms.

The first patient is a 67-year-old woman with hypertension and back pain who mentioned that she was bothered by a feeling that there was something in her naval, like a firm tubular object. A previous physician had told her this was normal. She claimed that when she coughed, she felt a pain in her navel, but that if she leaned forward and coughed, she felt nothing.

On examination, a round, blackish-brown keratinous deposit was found in the depths of the umbilical depression, and was easily extracted using a forceps. No umbilical hernia was noted. The object was composed of skin and other debris and measured 4 × 13 mm (Figure). It appeared to be oxidized, scale-encrusted keratotic material, similar to what is seen in giant open solar comedones. Once removed, the patient's symptoms were relieved.

The second patient is an 87-year-old woman who had severe dementia and resided in a nursing home. She complained of an irritating recurrent rash around the umbilicus. On exploration of the umbilicus, a large, round mass measuring 2 to 3 cm and located deep in the umbilical folds was found. It was removed with some difficulty by hooking a



probe behind it. Again, it appeared to be an oxidized keratotic concretion of skin debris. There was a foul, anaerobic smell from the umbilicus. The navel was irrigated and probed with peroxide and swabs, and the patient was started on cephalosporin for the cellulitis. One year later, on routine examination, another smaller umbilical calculus was found and easily removed. At the base of the umbilicus, there appeared to be a small sebaceous cyst. Again, 6 months later, more black keratotic debris was manually removed from the umbilicus, but it was not hard, and had caused no symptoms at the latter two visits. Perhaps this cyst was partially rupturing, releasing sebaceous material into the umbilicus, where it was oxidized and desiccated into an omphalokeratolith.[3]

I have reported two patients with symptomatic umbilical stones, both of which were manually removed with resolution of symptoms. Both patients had involuted, deep umbilical clefts which effectively sealed off the umbilicus, preventing normal hygiene of the area.

Marc S. Berger, MD
Stroudsburg, Pennsylvania

References

1. Imaizumi T. Un cas d'omphalithe chez un patient atteint de verrue séborrheique de l'ombilic. Ann Dermatol Venereol 1989; 116:27–8.
2. Ehring F. Omphalolith. Hautarzt 1979; 30(9):494–6.
3. Friedman SJ, Liles WJ. Omphalokeratolith. Cutis 1987; 40(2):144–6.

LOW-RISK PREGNANCIES

To the Editor:

We read with interest the study by MacDonald and colleagues[1] that examined outcomes in low-risk obstetrics. Considering the fact that approximately 1% of the neonates were intubated and less than 1% of the neonates had Apgar scores of less than 6 at 5 minutes, we find it surprising that 11.9% of the infants were transferred to an intensive care unit. This is twice the rate that has been reported in other studies.[2–5]

David L. Gaspar, MD
Department of Family Medicine
Wayne State University
Detroit, Michigan

John Jordan, MD
Department of Family Medicine
University of Western Ontario
London, Ontario

References

1. MacDonald SE, Voaklander K, Birtwhistle RV. A comparison of family physicians' and obstetricians' intrapartum management of low-risk pregnancies. J Fam Pract 1993; 37:457–62.
2. Wanderer MJ, Suyehira JE. Obstetrical care in a prepaid cooperative: a comparison between family practice residents, family physicians and obstetricians. J Fam Pract 1980; 11:601–6.
3. Reid AJ, Carroll JC, Ruderman J, Murray MA. Differences in intrapartum obstetric care provided to women at low risk by family physicians and obstetricians. Can Med Assoc J 1989; 140:625–33.
4. Krikke EH, Bell NR. Relation of family physician or specialist care to obstetric interventions and outcomes in patients at low risk: a western Canada cohort study. Can Med Assoc J 1989; 140:637–43.
5. Rosenberg EE, Klein M. Is maternity care different in family practice? A pilot matched pair study. J Fam Pract 1987; 25:237–42.

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

I would like to thank Drs Gaspar and Jordan for pointing out the need for clarification regarding infant transfer to the neonatal intensive care unit (NICU). Kingston General Hospital does not have a Level 2 nursery. At the time of the study, the local guidelines for transfer of infants to the NICU were very liberal. These included all cesarean section infants and any infants in whom meconium was present at delivery. Most of the infants who were transferred were perfectly well.

Our current guidelines for transfer are more realistically based on true need. We expect our current statistics for transfer to be more compatible with those of the previous studies mentioned by Drs Gaspar and Jordan.

Susan E. MacDonald, MD
Department of Family Medicine
Queen's University
Kingston, Ontario