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PSYCHIATRIC INTERVIEW

To the Editor:

I found the patient history interview proposed in the article by Dr Zimmerman¹ 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.

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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
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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 navel, 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

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.¹⁻³ Also dizziness, headache, skin flushing reported when used orally.¹⁻³

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.¹⁻³ 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.¹

How Supplied: Oral tablets of YOCON[®] 1/12 gr. 5.4mg in bottles of 100's NDC 53159-001-01, 1000's NDC 53159-001-10 and Blister-Paks of 30's NDC 53159-001-30.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188, McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

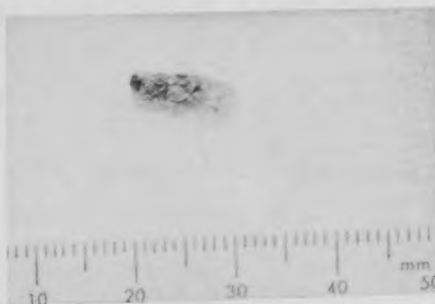


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Letters to the Editor



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.

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References

1. Imaizumi T. Un cas d'omphalithe chez un patient atteint de verruve séborrhéique de l'ombilic. Ann Dermatol Venerol 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 colleagues¹ 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

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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.

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