Letters to the Editor

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DYSLIPIDEMIC HYPERTENSION

To the Editor:

I read with interest the recent article by Eaton and associates[1] in which the term "Syndrome X" was mentioned. The term "Syndrome X" was used by Reaven[2] in his Banting lecture in 1988 to refer to the association of dyslipidemia, hypertension, coronary artery disease, glucose intolerance, and insulin resistance.

Unfortunately, the term "Syndrome X" was originally used by Kemp[3] in an editorial published in 1973 to describe the anginal syndrome with normal coronary arteriograms. Reaven's use of the same term to describe a totally different syndrome created much confusion. Because insulin resistance is thought to be the underlying defect of this syndrome, Haffner and associates[4] adopted the term "insulin resistance syndrome."

The term "insulin resistance syndrome" is preferable to "Syndrome X" for two reasons:

1. There is already a "Syndrome X" in the literature. Although no medical specialty has a monopoly on any terminology, it is confusing to have the same term applied to two entirely different entities in the medical literature.

2. "Insulin resistance syndrome" highlights the presumed pathogenetic sequence.

If endocrinologists insist on borrowing from cardiologists the term "Syndrome X," they should at least call it the "metabolic syndrome X"[5] to distinguish it from the "coronary syndrome X."[6] On rare occasions, the two may coexist.[7]

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References

1. Eaton CB, Feldman HA, Assaf AR, McPhillips JB, Hume AL, Lasater TM, et al. Prevalence of hypertension, dyslipidemia, and dyslipidemic hypertension. J Fam Pract 1994; 38:17–23.
2. Reaven GM. Role of insulin resistance in human disease (Banting lecture 1988). Diabetes 1988; 37:1595–607.
3. Kemp HG. Left ventricular function in patients with the anginal syndrome and normal coronary arteriograms. Am J Cardiol 1973; 32:375–6.
4. Haffner SM, Valdez RA, Hazuda HP, Mitchell BD, Morales PA, Stern MP. Prospective analysis of the insulin resistance syndrome (Syndrome X). Diabetes 1992; 41:715–22.
5. Koutis AD, Lionis CD, Isacsson A, Jakobsson A, Fioretos M, Lindholm LH. Characteristics of the 'Metabolic Syndrome X' in a cardiovascular low risk population in Crete. Eur Heart J 1992; 13:865–71.
6. Cheng TO. Which Syndrome X? Eur Heart J 1993; 14:143.
7. Bøtker HE, Møller N, Ovesen P, Mengel A, Schmitz O, Ørskov H, et al. Insulin resistance in microvascular angina (syndrome X). Lancet 1993; 342:136–40.

To the Editor:

The recent paper by Eaton et al[1] describing the syndrome of dyslipidemic hypertension requires comment. Although the authors' sample size is large, its value is diminished because few if any patients had lipid determinations on fasting blood. All major studies on atherosclerosis regression have used fasting blood. (While the Framingham Heart Study has used nonfasting blood, that study is not a study of atherosclerosis regression.) Since the only reason to identify dyslipidemic patients is to offer treatment to those at risk for atherosclerotic disease (ASD), and since triglyceride (TG) levels vary widely in the nonfasting state, the use of nonfasting blood for lipid determination should be proscribed. After all, the key lipid indicators in ASD are low-density lipoprotein (LDL) cholesterol and high-density lipoprotein (HDL) cholesterol, and their determination requires fasting blood.

Even so, the syndrome of dyslipidemic hypertension is real and widespread. I have reported the results of my investigations into the relation between hypertension and dyslipidemia.[2,3] As of January 1, 1994, I have studied fasting lipids in 116 male and 100 female patients with "incidental hypertension." I take blood pressure determinations on all patients who come to my office, and all with sustained systolic blood pressures over 140 mm Hg are invited to have a fasting lipid determination, as well as a 2-hour postprandial glucose test.[3] Eighty-one percent of these male patients and 61% of female patients have untreated hypertension. Although the number of my patients is small by comparison with that of Eaton's study, mine *all* have fasting lipid studies.

I have previously defined a cholesterol threshold (CThr) as a risk factor in which the cholesterol retention fraction (CRF, or [LDL − HDL]/LDL) exceeds 0.69 or the LDL exceeds 169 mg/dL.[3] With this in mind, I have found lipid abnormalities in patients with incidental hypertension, as detailed in the Table. The patients reported represent all age groups. The percentage of abnormalities is higher if patients under the age of 30 years or over the age of 80 years are deleted.

The point of this letter is to remind physicians that they must be cognizant of lipid abnormalities when treating hypertensive patients. Various antihypertensive agents have adverse lipid effects that worsen lipid profiles.[4–6] That this is not inconsequential is borne out by the finding that patients with dyslipidemic hypertension who have never smoked but who develop some manifestation of clinical atherosclerotic disease do so at an earlier age than do their normolipidemic counterparts—for men, 73 years and 79 years, respectively, and for women, 71 and 77 years, respectively (my unpub-

Table. Lipid Abnormalities in Patients with Incidental Hypertension

Lipid Indicators	Patients with Abnormal Findings, %	
	Men	Women
Cholesterol threshold	54	49
Total cholesterol	19	33
High-density lipoprotein	38	20
Low-density lipoprotein	19	25
Triglyceride	52	50

lished data). Moreover, the worse the lipid abnormality, the earlier is the onset of clinical disease. My rule, therefore, is, "Never sacrifice cholesterol on the altar of hypertension."

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References

1. Eaton CB, Feldman HA, Assaf AR, McPhillips JB, Hume AL, Lasater TM, et al. Prevalence of hypertension, dyslipidemia, and dyslipidemic hypertension. J Fam Pract 1993; 38:17–23.
2. Feeman WE Jr. Lipids and hypertension. JAMA 1989; 261:2954.
3. Feeman WE Jr. The Bowling Green study of the primary and secondary prevention of atherosclerosis. Ohio J Sci 1992; 92:153–81.
4. Hegeland A, Hjerman I, Leven P, et al. High density lipoprotein cholesterol and antihypertensive drugs. BMJ 1978; 2:403.
5. McKenney JM, Goodman RP, Wright JT Jr, et al. The effect of low-dose hydrochlorothiazide on blood pressure, serum potassium, and lipoproteins. Pharmacotherapy 1986; 6:179–84.
6. Pool SC. Effects of doxazosin on serum lipids. Am Heart J 1991; 121:251–60.

The preceding letters were referred to Dr Eaton, who responds as follows:

Dr Cheng appropriately mentions the confusion regarding the term "Syndrome X," which is used differently in the endocrine and cardiology literature, and suggests adopting the term coined by Haffner, "insulin resistance syndrome." Some experts feel insulin resistance can be determined only by euglycemic clamp procedures and, therefore, insulin resistance can be ascertained only in a research setting. We have used the more descriptive term "dyslipidemic hypertension," which is easy to assess clinically.

Dr Feemen shares with us his data on 216 hypertensive patients, many of whom have abnormal lipid profiles consistent with our findings. Although fasting specimens would have been preferable in our study, since this was a population-based study, blood was drawn in the subjects' homes throughout the day. We did use values of fasting specimens to define our abnormal lipid profiles. In the discussion section, we discuss the implications of not using fasting specimens.

We disagree with Dr Feeman that the key lipid indicators in atherosclerosis disease can be emphatically stated to be low-density lipoprotein (LDL) cholesterol and high-density lipoprotein (HDL) cholesterol. Evidence that postprandial chylomicrons, apo-β-containing LDL and very low-density lipoprotein (VLDL) cholesterol, intermediate-density lipoprotein (IDL) cholesterol, and lipoprotein(α), may be important in the etiology of atherosclerosis and clinical coronary heart disease and are increasingly being reported in the medical literature.[1–4]

We do agree with the main point of Dr Feemen's letter that physicians should be aware of lipid abnormalities in hypertensive patients. The main clinical point of our article was that exercise and weight loss, both of which are therapies for insulin resistance, should be first-line therapy for dyslipidemic hypertension, given the potential causative role of insulin resistance in its etiology.

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References

1. Simons LA, Dwyer T, Simons J, Bernstein L, Mowe P, Poonia NS, et al. Chylomicron and chylomicron remnants in coronary artery disease: a case-control study. Atherosclerosis 1987; 65:181–9.
2. Kwiterovich PO, White S, Forte T, et al. Hyperapobetalipoproteinemia in a kindred with familial combined hyperlipidemia and familial hypercholesterolemia. Arteriosclerosis 1987; 7:211.
3. Tatami R, Mabuchi H, Veda K, et al. Intermediate density lipoprotein and cholesterol-rich very low density lipoprotein in angiographically determined coronary artery disease. Circulation 1981; 64:1174–84.
4. Rosengren A, Wilhelmsen L, Eriksson E, et al. Lipoprotein(α) and coronary heart disease: a prospective case-control study in a general population sample of middle aged men. BMJ 1990; 301:1248–51.

COLONOSCOPY

To the Editor:

I read with interest and concern a case report by Weber et al (*Weber DJ, Rodney WM, Warren J. Management of suspected perforation following colonoscopy: a case report. J Fam Pract 1993; 36:567–70*) regarding colonic perforation after colonoscopy. As the authors appeared to understand, the case likely involved a transmural burn rather than a perforation.

I was particularly alarmed by the prepolypectomy management of the case. The patient had an initial full colonoscopy performed by Dr Rodney, at which time polyps were identified but, for reasons not given, were not removed. Two weeks later, he was admitted to the hospital, where Dr Rodney performed another colonoscopy and removed the polyps.

It is widely held by the endoscopic community to be unacceptable to perform colonoscopy without intent to remove polyps during the initial procedure. The adverse consequences of Dr Rodney's approach in this case are several: (1) the patient was subjected to both the risk and inconvenience of another bowel preparation, a repeated sedation, and a second insertion of the colonoscope; (2) the patient and society incur the financial burden of an additional lost day from work; (3) the patient and the health care system incur the cost of a second unnecessary colonoscopy. Hopefully, Dr Rodney did not submit physician's fees for two colonoscopies. Finally, admission to the hospital for polypectomy is seldom appropriate. No adequate explanation for admission was provided in this case, and all costs associated with this admission appear inappropriate.

I hope the family practice community will recognize and avoid the deficiencies evident in the management of this case. Colonoscopy, whether performed in the office or hospital, in inpatients or outpatients, should be performed with intent to clear the colon of endoscopically removable neoplasia during the initial examination.

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

The concern of Dr Rex regarding this one patient who underwent two colonoscopies ignores the vast larger number of patients who underwent only one. When Dr Rex refers to so-called standards "widely held by the endoscopic community to be unacceptable," he is simply furthering the self-serving rhetoric of many gastroenterologists throughout this country who wish to maintain their economic monopoly and training cartel.[1]

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A second colonoscopy is not necessarily a rare or risky event in day-to-day practice. There are a substantial number of patients in whom bowel preparations are inadequate, despite the best of intentions. These patients may undergo a second colonoscopy once a polyp is found. In patients with multiple lesions, some physicians will remove two or three polyps at one sitting and bring patients back for a second colonoscopy to remove additional polyps.

There are issues of access, cost, and emotional morbidity. In our community, patients appreciate returning to a familiar office, where they can be scheduled with ease and convenience. Continuity is usually maintained in this setting, whereas it is rarely maintained by premature referral. The cost of our colonoscopy procedures is 50% lower than those of hospital-based gastroenterologists.

Some gastroenterologists will not accept Medicaid or the new version of it here in Tennessee (TennCare). In some areas of the state, patients are needlessly traveling 60 to 100 miles in search of a physician who will perform colonoscopy. This residency program believes that rural and underserved communities will benefit from having well-trained colonoscopy-capable family physicians.[2,3]

When a difficult case is encountered, it is appropriate that these cases be referred. Our primary purpose is the delivery of low-cost, high-quality, accessible health care to all patients, regardless of ability to pay. Although Dr Rex has focused on this numerator case, he should be happy to know that patients with a potential for colorectal cancer are being offered and receiving colonoscopy services through a well-established primary care network. If gastroenterologists have some plan demonstrating their ability to provide these services to rural or underserved communities, they should publish it.

Instead, their specialty societies, led by the American Society for Gastrointestinal Endoscopy (ASGE), have chosen to launch a series of political, economic, and pseudoscientific attacks on all who challenge their right to maintain a monopoly on colonoscopy services. The ASGE has unilaterally doubled the number of procedures needed for obtaining credentials in their system. In conjunction with other gastroenterology societies, they have hired an attorney to create a legal opinion that suggests malpractice risk for all who violate their standards. This opinion was mailed to every hospital in every state in the United States.[1] In doing so, they have created hundreds of hours of additional administrative costs for small-town hospitals all over this country. In my opinion, these actions have made it more difficult for the American public to receive effective preventive medicine services in the area of colorectal cancer.

We thank Dr Rex for the opportunity to clarify the language regarding admission to the hospital. The patient was admitted as an outpatient to the GI endoscopy suite for polypectomy. The patient was not admitted overnight. This is the standard-of-care for most of these kinds of procedures, whether they are performed by gastroenterologists, surgeons, family physicians, or general internists. It is probable that all of these physicians will have the opportunity to receive training in and to perform endoscopy procedures during the 21st century.[4–6] Gastroenterologists should prepare themselves for the strong possibility that they will be consultants for the minority of endoscopic cases that cannot be performed by primary care providers.[7]

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References

1. Zuber TJ, Pfenninger JL. Interspecialty wars over endoscopy [editorial]. J Fam Pract 1993; 37:21–2.
2. Carr KW, Rodney WM. Support for colonoscopy in rural family practice. Tenn Fam Physician 1993; 5(1):4.
3. Rodney WM, Dabov G, Cronin C. Evolving colonoscopy skills in a rural family practice: the first 293 cases. Fam Pract Res J 1993; 13(1):43–52.
4. Rodney WM. Flexible sigmoidoscopy and the despecialization of gastrointestinal endoscopy: an environmental impact report. Cancer 1992; 70:1266–71.
5. Rodney WM, Weber JR, Swedberg JA, Gelb DM, Coleman WH, Hocutt JE, et al. Esophagogastroduodenoscopy by family physicians. Phase II: a national multisite study of 2,500 procedures. Family Pract Res J 1993; 13:121–31.
6. Rodney WM, Dabov G, Orientale E, Reeves WP. Sedation associated with a more complete colonoscopy. J Fam Pract 1993; 36:394–400.
7. Maule WF. Screening for colorectal cancer by nurse endoscopists. N Engl J Med 1994; 330:183–7.

ALZHEIMER'S DISEASE

To the Editor:

We enthusiastically commend Dr Elizabeth Roth on her comprehensive review of Alzheimer's disease for the generalist physician.[1] There is one point of the article, however, on which we wish to raise a concern. Dr Roth recommends that all patients with suspected Alzheimer's disease receive, among other tests, a head imaging study (computed tomography [CT] or magnetic resonance imaging [MRI]), electrocardiogram, chest radiograph, syphilis and human immunodeficiency virus (HIV) testing, and measurement of vitamin B_{12} level. The *routine* use of these tests in the dementia workup has not been shown to be helpful, either in diagnosing the dementia type or in detecting a reversible disorder.[2,3] Obtaining these tests indiscriminantly for every case of dementia encountered would greatly add to the diagnostic cost.

Many authors recommend selective use of these tests as the individual situation dictates. For example, a head imaging study (CT or MRI) should be ordered only in dementia cases of recent onset (ie, weeks or months) or when the clinical picture is suspect for subdural hematoma, brain tumor, or perhaps normal pressure hydrocephalus.[4] We submit that family physicians can accurately diagnose Alzheimer's disease in the majority of cases on the basis of a careful history, physical examination, and a modest battery of laboratory tests (complete blood count, metabolic screen, and thyroid studies). Further testing should be reserved for dementia cases with a presentation that is not consistent with criteria for the clinical diagnosis of probable Alzheimer's disease.

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References

1. Roth ME. Advances in Alzheimer's disease. A review for the family physician. J Fam Pract 1993; 37:593–607.
2. Larsen EB, Reifler BV, Sumi SM, Canfield CG, Chinn NM. Diagnostic tests in the evaluation of dementia. A prospective study of 200 elderly outpatients. Arch Intern Med 1986; 146:1917–22.

3. Siu AL. Screening for dementia and investigating its causes. Ann Intern Med 1991; 115:122–32.
4. Clarfield AM, Larsen EB. Should a major imaging procedure (CT or MRI) be required in the workup of dementia? An opposing view. J Fam Pract 1990; 31: 405–10.

MILITARY FAMILY PHYSICIANS

To the Editor:

The family practice staff and residents at the Naval Hospital, Bremerton, Washington, would like the opportunity to briefly respond to the decision by the editors to send *The Journal of Family Practice* to all military family physicians. At the same time and in the same fashion, we would like to comment on the editorial by Dr Henley in the January 1994 issue of The Journal (*Henley CE. Military family practitioners join the ranks of* The Journal of Family Practice. *J Fam Pract 1994; 38:15–6*).

THANK YOU VERY MUCH!

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CORRECTION

Pelmear PL, Taylor W. Hand-Arm Vibration Syndrome (February 1994; 38:180–5).

On page 182, left-hand column, first complete paragraph: The first two mentions of adrenoceptors should have read "α_2 adrenoceptors," *not* α_1.

On page 183, right-hand column, under heading Treatment and Management, 2nd paragraph: Sentence should have read, "To reverse the pathology and achieve recovery, further vibration exposure should be avoided." In the 4th paragraph under the same heading, citation 35 should have read citation 14.

EMPEROR'S NEW CLOTHES

To the Editor:

In the editorial entitled "The Emperor's New Clothes," Dr Fischer correctly indicates that proposed federal health care legislation carries significant risks for family physicians who "will be at the center of the conflict between those who desire care and those who profit by its rationing."[1] It may be useful to pursue his analogy between the present situation and the mythical emperor's state of dress (or lack thereof) in further detail. There are many flawed characters in the story: the monarch who willingly believes what is not so, the people in the streets who "go along" without thinking for themselves, and the weavers who, with great showmanship, produce nothing. The analogy between the obtuse sovereign and present-day political leaders who would place full responsibility for controlling health care costs on physicians, hospitals, and other providers may be valid: we could be expected to accomplish the impossible and pay a political price for failing to do so.

Nevertheless, members of the medical establishment, like the weavers in the fable, are partly responsible for the present crisis and must become actively involved in its correction. Americans are now paying more for health care than for national defense and education combined. Hostility from legislators and business executives toward the health care system is inevitably a consequence of the impact that exploding medical bills are having on their budgets. Costs are badly out of control, the present rate of increase is not politically or economically sustainable, and (in naval parlance) it happened on our watch.

This situation presents unprecedented opportunities for family medicine, the risks mentioned above notwithstanding. Our orientation to comprehensive, continuity-oriented patient management, coupled with our critical skills and unwillingness to accept clinical dogma blindly, makes it possible for us to provide care that saves money and simultaneously gives better outcomes than today's fragmented, technology-heavy treatment styles. For example, utilizing the biopsychosocial approach to our backache patients will minimize the probability of their becoming "disabled"; managing our asthmatics astutely will minimize their need for costly emergency department or inpatient treatment; initiatives to reduce the incidence of smoking among our patients will reduce their long-term risk of developing cancers and heart disease; and appropriate skepticism, clinical investigation, and prompt utilization of research findings will reduce the amount of wasteful, ineffective treatment.[2–6] Our greatest strength is our focus on a style of health care that is both beneficial and cost-effective, and our greatest challenge is to make it more so through research and wider application of presently available knowledge.

It does not follow from the foregoing that greater efficiency alone will solve the cost problem. Useful but higher-priced technology will continue to appear. The Human Genome Project[7] alone could lead to ever more expensive diagnostic and treatment methods, which, if adopted without restriction, could overwhelm the nation's ability to pay the bills. Any viable system that proposes to serve everyone must contain some method of choosing which services we must provide and which we cannot afford. Addressing this hard reality will require a major paradigm shift for many people (health professionals and others), but resolution of the present crisis will elude us until it is made.

Resource allocation, or rationing, will necessarily be recognized at some point as both inevitable and socially useful.[8] We should thus see "case management" not as something to be ashamed of, but rather as a difficult, demanding, socially valuable task that deserves our best efforts. The nation's choice is not, as some have suggested, between excellent care provided largely by limited specialists and cheap management controlled by family physicians and other primary care physicians: global outcomes will improve with wider availability of high-quality primary care services. Referral of difficult cases to subspecialists will continue, but it will be more selective in the new era than it is now. Coordinating the treatment of patients with complex needs will be accomplished more efficiently than it has been heretofore. Provision of futile care will decrease as we learn to assess futility and lack of efficacy more clearly and precisely than we do now.

James Russell Lowell once observed, "Mishaps are like knives, that cut us or serve us as we grasp them by the blade or by the handle." These are excit-

ing times for family medicine. They are undeniably risky, but the hazards are manageable and possibilities are great if we can grasp the opportunities firmly and employ them wisely.

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References

1. Fischer PM. The emperor's new clothes. J Fam Pract 1993; 37:543–4.
2. Orr PH, Scherer K, Macdonald A, Moffatt MEK. Randomized placebo-controlled trials of antibiotics for acute bronchitis: a critical review of the literature. J Fam Pract 1993; 36:507–12.
3. Grimes DA. Technology follies: the uncritical acceptance of medical innovation. JAMA 1993; 269:3030–33.
4. Smith GF, Madlon-Kay DJ, Hunt V. Clinical evaluation of ankle inversion injuries in family practice offices. J Fam Pract 1993; 37:345–8.
5. Berkowitz RL. Should every pregnant woman undergo ultrasonography? N Engl J Med 1993; 329:874–5.
6. Turner JA, Denny MC. Do antidepressant medications relieve chronic low back pain? J Fam Pract 1993; 37:545–53.
7. Wilfond BS, Nolan K. National policy development for the clinical application of genetic diagnostic technologies: lessons from cystic fibrosis. JAMA 1993; 270: 2948–54.
8. Aaron H, Schwartz WB. Rationing health care: the choice before us. Science 1990; 247:418–22.

Dr Fischer responds to the preceding letter as follows:

As Thoreau said, "Beware of all enterprises that require new clothes."

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