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URTI MANAGEMENT

To the Editor:

To isolate the clinician's behavior from the community (as apparently was done in the comparative study on upper respiratory tract infections by de Melker and Kuyvenhoven¹) is to overlook cultural variables that may have a significant impact on physician decisions. The editors commend recent clinically oriented research?² I concur and furthermore suggest attention to patient expectations that can coerce physician decisions. Do Dutch attorneys feed off their physicians? Do Dutch claims of undocumented penicillin allergies force avoidance of amoxicillin as is done in the United States? Are our patients compliant—are they Dutch?

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The preceding letter was referred to Drs de Melker and Kuyvenhoven, who respond as follows:

Dr Wilson has raised several issues that are important for family practice from an international perspective. He is right to underline the importance of cultural factors in the management of health problems, especially for prescription and referral behavior related to common diseases, such as upper respiratory tract infections (URTIs). This is one of the major reasons we published our URTI paper in an American journal.¹ We are quite aware that cultural factors are important determinants affecting physician decisions. In *Medicine and Culture*, American sociologist Lynn Payer, who lived in Europe for a long time, states that national culture and philosophy affect the care doctors deliv-

er.² She describes how important it is to recognize differences in health care and payment systems in order to understand differences in how that care is delivered. Many of our decisions are based only partially on scientific knowledge, or not at all. She writes, for instance, that American medicine is rather aggressive and that American doctors want to *do* something in each case. In our own experience, the American approach to URTIs is different from that of the Dutch. American physicians initially treat with antibiotics, while the Dutch consider many URTIs to be self-limiting. Because our insights are colored by our cultural background, understanding cultural factors can improve medical care, making it more rational and less based on our "experience" and beliefs.³ More information on Dutch health care is available.⁴

The data in our paper are from 1988, other studies show the same trend,^{5,6} and we are quite sure that our results are valid for the Netherlands.

Patient expectations do influence physician decisions, as they should. However, we believe these expectations reflect physician behavior.⁷ Studies have shown that differences in prescription and referral rates are correlated with doctor-related factors. Moreover, studies have shown that family doctors overestimate the expectations of their patients to do something (eg, prescribe drugs).⁷⁻⁹ In addition, we have shown that personal attitudes about prescribing antibiotics for URTIs become less influential after the beginning of the vocational training for general practice.¹⁰

Even in Holland, the American custom of suing is well-known. In our country, malpractice claims are increasing but are still very limited as compared with the USA. Our patients may even complain because the family doctor overprescribed medications! As we indicated our article, the Dutch College of Family Doctors has developed guidelines in which the specific criteria for diagnostic procedures, prescription, and referrals play a major role. These guidelines are very important in judging liability.

We thank Dr Wilson for his comments and hope that this will be the start of an exchange of research results, ideas, and

experiences from an international perspective.

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POOR PARENTING SKILLS

To the Editor:

Physicians who care for women prenatally and then care for their children have always noticed that some women have difficulty parenting. Several factors may be predictive of poor parenting including lack of education on child-rearing, stress, poor coping skills, and poor social and family supports. Identifying

such women and children prenatally is much more difficult than expected.

Poor parenting can lead to failure-to-thrive, unhappy babies and mothers, and perhaps maltreatment.¹⁻³ One way to identify such families and the children at risk once the child is born and growing is by noting excessive visits to the office and hospital emergency department (ER).^{4,5} If these families could be identified prenatally, an intervention might be devised to help them before poor parenting occurs.⁶⁻⁸

A retrospective chart review of all mothers and children seen prenatally and then after delivery at the Bristol Family Practice Center between January 1991 and July 1994 was accomplished. The purpose of the study was to identify a group of mothers at high risk for parenting difficulties.

Nine variables were recorded from each mother's chart: age, marital status, gravidity, trimester of first prenatal visit, family APGAR, regularity of attendance at prenatal visits, smoking history, whether the pregnancy was planned, and if the family had moved in the 6 months prior to pregnancy. The children's charts were investigated for number of office and ER visits per month. If the child was born prematurely or had chronic, serious, or recurrent illnesses, the mother and child were excluded from the study. The charts of 197 mother-child pairs were identified, and the children were followed an average of 10.5 months.

The population was 98% white and 2% black. Just over 40% were married; the rest were separated, single, divorced or widowed. Fifty percent were primigravida, 51% smoked, and only 29.6% registered for prenatal care during the first trimester. Defining "excessive" visits to ER as more than 4 in 10 months and "excessive" office visits as more than 6 visits for illness, 25% to 28% of the group used the ER or office excessively. Mothers who used the ER too much also used the office excessively.

There were no significant variables or combinations of variables that could predict if a mother was going to be in the "excessive use" group. Thus, identifying mothers at risk for poor parenting is a complex problem that precludes easy prediction or classification by scoring systems. This is an important problem that needs a much greater in-depth method of identifying those factors.

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PSA SCREENING

To the Editor:

In their article about PSA screening for asymptomatic prostate cancer,¹ Drs Hahn and Roberts present an unreferenced table entitled Risks Associated with Prostatectomy and Radiation Therapy. Because of serious concerns regarding the reporting of complications associated with definitive external beam irradiation for adenocarcinoma of the prostate as cited in this article, I established a task force composed of several members of the American Society for Therapeutic Radiology and Oncology: David H. Hussey, MD, Colleen A. Lawton, MD, Steven A. Leibel, MD, and William U. Shipley, MD, all of whom are outstanding investigators in cancer research and the clinical management of prostate cancer. We find the article to be in error on several points, most seriously in citing the risk of urinary incontinence following radiotherapy as 8%, when in actuality it is less than 1%.

Extensive clinical data are currently available, from which one can accurately determine the risks of radiation therapy for prostate cancer. This information comes from multiple sources, including the Radiation Therapy Oncology Group (RTOG), a large, national, multi-institutional cooperative study group whose re-

sults are significant because of the large number of patients enrolled and multiple centers treating these patients. RTOG studies of over 1000 patients treated with radiation therapy regarding the incidence of death, urinary incontinence, rectal or other intestinal injury, urethral stricture and lymphedema²⁻⁴ associated with radical radiation therapy for prostate cancer have been performed. Death occurred in a total of two patients for an incidence of .2%. Total urinary incontinence occurred in two patients (.2%). Rectal or other intestinal injury occurred acutely in approximately 15% of patients treated, but presents a long-term problem in only 3.4% of all patients. Urethral stricture occurred in 46 patients (4.6%) but a urethral stricture or bladder neck contracture persisted (was not corrected endoscopically) in 1.6%. Finally, lymphedema occurred in seven (.7%) patients who had prior lymphadenectomy, but no patients without prior surgery experienced lymphedema.

With regard to impotence, we have to look at other data to understand the risk from radiation therapy, as this was not formally coded in the RTOG trials.^{5,6} The available data suggest that the risk of becoming impotent after irradiation if the patient is potent prior to irradiation, as your table indicates, is 40% or possibly higher. However, as many as 50% to 65% of the patients referred for radiation therapy are impotent prior to initiation of therapy. The problem in the table from the article is that risk of impotence after prostatectomy is erroneously listed at 20%. Even Dr Patrick C. Walsh, who developed the nerve sparing radical prostatectomy and carefully selects patients for such surgery, reports that only 50% of patients aged 60 and older remained potent after the operation.⁷ In younger, sexually active patients, the numbers improve dramatically, but adenocarcinoma of the prostate is not a disease of young men. Even Dr Walsh reports an overall impotence rate of 31%.⁷

We hope your readers will take the time to examine this information so that they can give their patients a more accurate view of the risks associated with radical radiation therapy for adenocarcinoma of the prostate.

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The preceding letter was referred to Drs Hahn and Roberts, who respond as follows:

To the Editor:

We appreciate the efforts of Dr Wilson et al to provide additional data describing the morbidity of radiation therapy for prostate cancer. Asymptomatic patients who contemplate being screened for prostate cancer should be provided

the best possible risk estimates of all the management options available. We fear, however, that Dr Wilson's group may have missed the central point of our editorial.¹ Our principal thesis was that the benefits of PSA screening are theoretical and as yet unproven, while the harms are real and predictable.

Dr Wilson and colleagues allege several errors in our table entitled "Risks Associated with Radical Prostatectomy and Radiation Therapy." They contend that the table is unreferenced. As cited in our editorial (page 433, reference 17), we used estimates developed by Mold et al² from a decision analysis for the evaluation and treatment of men with asymptomatic prostate nodules in a primary care setting. In their article, Mold and coauthors assumed that "the very best values can only be achieved under ideal conditions." The Mold analysis estimated an 8% incidence of postirradiation urinary incontinence; in their letter, Dr Wilson and colleagues contend that the incidence is less than 1%, based on data derived from Radiation Therapy Oncology Group (RTOG) centers.

We have concerns about the generalizability of RTOG data. By definition, RTOG centers represent some of the best radiation therapy centers in the country. It is debatable whether similar complication rates can be achieved in the community setting, where most screen-detected prostate cancer patients would be treated. Moreover, the RTOG data cited reflect a wide range of men with prostate cancer—some with localized disease, others with advanced disease; some detected by screening, others with symptoms. Whether Dr Mold's 8% estimate or Dr Wilson's less-than-1% estimate proves the more realistic complication rate is less important than the fact that *some* percentage of asymptomatic men will develop urinary incontinence as a result of undergoing

screening for and radiation treatment of prostate cancer.

What is most important is the creation and continued revision of tables like the one we developed so that new information can be incorporated into discussions with patients. For example, based on a more representative population-based study of prostatectomy³ that was published after our editorial, we have suggested a modification of our table.⁴ It is interesting to note that longer term follow-up indicates an even higher rate of complications for prostatectomy than the previous literature suggests.

Our patients deserve the best information we can share with them. The best information is that which accounts for the inevitably wide range of experimental results reported from research settings, is tempered by the usual results seen in their community settings, and predicts most accurately the outcomes patients can expect to experience.

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