

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.

## MORE MALAPROPISMS

To the Editor:

I share Davis's and Kenyon's (*Davis SW, Kenyon TM. Medical malapropisms [or a stitch in time gathers no moss]. J Fam Pract 1995; 40:119-20.*) fascination with medical malapropisms, though I consider such events not "misterminologies" but inevitable transformations. These occur spontaneously when any language is adopted by a new community. While many examples involve no more than phonemic shifts from one neutral term to another (like *Pack* smear for Pap Smear, or *Latex* for Lasix), very often the new constructions are full of meaning. Such phrases as "old-timer's disease" and "sick-as-hell anemia" reflect an active although unwitting effort on the patient's part to make sense of technical jargon, to coordinate the *name* of a process with the *experience* of that process. At my own hospital, *cadillac* arrest (cardiac), *high achin'* hernia (hiatal), and even the artistic child (autistic) are demonstrative of this effort. One patient presented to my office with an inflamed toe and announced: "Doctor, I've got the gouch!" If only our medical language were so evocative.

As Davis and Kenyon suggest, patients are not the only perpetrators. After a difficult Balint session last month, I returned to the office where an uncircumcised man complained of irritation of his foreskin and glans. I documented in the chart my diagnosis of "recurrent balantitis."

Hospital unit clerks must struggle on a daily basis to decipher doctors' inscrutable orders, so it is not surprising that a clerk should commit my favorite malapropism. She was asked to arrange hematology consultation for a patient with thrombocytopenia. The department received this message: "Throbbing penis, please evaluate."

Joel Lazar, MD  
Thomas Jefferson University  
Philadelphia, Pennsylvania

To the Editor:

I very much appreciated "Medical Malapropisms" (*Davis SW, Kenyon TM. Medical malapropisms [or a stitch in time gathers no moss]. J Fam Pract 1995; 40:*

119-20). The authors have asked the readership to share medical malapropisms they have encountered. I can offer a few:

- Years ago, I was interviewing a patient who had been verbally and apparently physically abused by her alcoholic husband. Describing the latest situation in which her husband had acted up, she said, "He *misconscrews* everything I say. I just asked him what he was doing at the bar when one of my friends saw him with another woman, and he *conscrewed* that all wrong and clipped me up along the head."

Also heard in the examining room:

- "My brother said he would be *renumerated* for the work he was doing." (Even the media are now saying *renumerated* for *remunerated*, so it may be the wave of the future.)
- "My grandmamma had *oldtimer's* disease" (Alzheimer's).
- "The doctor said he had *chain strokes*" (Cheyne-Stokes asthma).
- "After his operation, I couldn't talk to him until he came *true*."

Not all medical malapropisms are committed by the licensed unsophisticated:

- The term *grasping for air* is heard often. Recently on Channel 7 in Chicago, an ex-athlete sports announcer used this phrase to describe the fatigue of the Boston University football team during their come-from-behind attempt against the University of Michigan.
- In a physical diagnosis writeup relating a patient's history of a rash, a medical student wrote, "The patient *contributes* his rash to the medications he was taking" (attributes).
- Another student, while making an otherwise decent argument in an academic discussion, said, "That's a *mute* point." As with many other malapropisms, there's method in this madness: most mute points *are* moot.
- Another medical student, who seems to be in great company these days, said his patient's abdomen was *protruberant*, combining *protruding* and *protuberant*.

David R. Rudy, MD  
Finch University of Health Sciences  
North Chicago, Illinois

To the Editor:

In reviewing Davis and Kenyon's list of "Medical Malapropisms" (*Davis SW, Kenyon TM. Medical malapropisms [or a stitch in time gathers no moss]. J Fam Pract 1995; 40:119-20.*), I noted two that could possibly have resulted from speaking English as a second language rather than simply from poor English usage.

The word *escape* in "I became an escape goat" could well have been the result of a Spanish speaker adding an "e" to the beginning of an English "sc" word. This is common in Spanish: *escalpelo* for scalpel; *escarlata* for scarlet; *escéptico* for sceptic; *escuela* for school; and so forth.

The word "constipated" in "My son's nose is constipated" could have been the result of trying to literally translate the Spanish word "constipado," which indeed means "congested" in English. The Spanish word for "constipated" is "estreñido."

I wonder if any other "malapropisms" might be the result of similar foreign language maladaptations? If so, the speakers should be given an "A" for effort, not a "U" for *Humor in Medicine*.

Marc Tunzi, MD  
Family Practice Residency Program  
Natividad Medical Center  
Salinas, California

The preceding letter was referred to authors Davis and Kenyon, who respond as follows:

To the Editor:

Dr Tunzi makes an insightful observation about the possible derivations of two of the medical malapropisms in our article (*Davis SW, Kenyon TM. Medical malapropisms [or a stitch in time gathers no moss]. J Fam Pract 1995; 40:119-20.*) In fact, the speaker who said "My son's nose is always *constipated*" is a person of Hispanic origin. However, the other malapropisms were expressed by people whose primary language is English. It was not our intention to give anyone a "U," but as we stated in the article, we offer the malapropisms as examples of how language is assimilated and reflected, regardless of the speaker's primary language. Having chuckled at our own misterminologies, we recognize that the misuse of language occurs universally, whether be-



cause of "Freudian slips," simple word similarities, or second-language adaptations. We see them as adding insight into the breadth and versatility of English, and indeed we applaud those who are learning such a difficult, complex language.

Stephen W. Davis, MD  
Tina M. Kenyon, ACSW  
Brown University  
Department of Medicine  
Pawtucket, Rhode Island

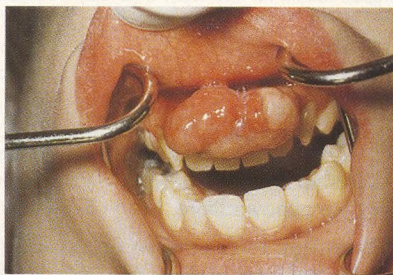


Figure. Pyogenic granuloma ("pregnancy tumor") of the mandibular labial gingival exhibiting a lobulated surface with a yellowish-white membrane. This type of lesion is usually erythematous and not related to pulp disease.

## PYOGENIC GRANULOMA

To the Editor:

I report an unusual case of a rapidly developing gingival tumor that occurred as a late complication of pregnancy.

A 25-year-old gravid woman was referred by her primary care physicians and dentist for periodontal evaluation of a large, exophytic red mass with pedunculated base located on the facial attached tissue of the mandibular central incisors. The patient was not in pain. Her chief complaint was fear about the severe spontaneous hemorrhaging from this lesion. Her dental history indicated that had been having her teeth cleaned twice a year, and she had no knowledge of having periodontal disease. At the time of her evaluation, the patient reported that her baby was due in approximately 1 week.

The lesion had appeared 1 week earlier and had grown extremely quickly. The intraoral and radiographic examination revealed that this patient had an existing inflammatory periodontal condition known as "pregnancy gingivitis" throughout the entire mouth. The surface of the lesion was lobulated and covered with a yellowish-white membrane (Figure). An excisional biopsy of this large lesion was performed 2 weeks postpartum. The mandibular incisor region was anesthetized and the entire pedunculated stalk of the lesion dissected free from the underlying periosteum. Histology revealed pyogenic granuloma.

During pregnancy, the interdental gingival tissues are likely to become inflamed. Increases in both tooth mobility and probing pocket depths can result.<sup>1</sup>

Balligan and Hale<sup>2</sup> recently reported that gingival inflammatory changes are much more clinically significant during pregnancy than during the postpartum period. These tissue changes also can occur at the end of the first trimester, but, as demonstrated by this case, these gingival aberrations can develop very late and rapidly in the third trimester.

The oral pyogenic granuloma, known as a "pregnancy tumor," can be conservatively treated successfully in many cases with scaling under local anesthesia during pregnancy. As reported by Tarsitano and Rollings,<sup>3</sup> many obstetricians believe that since these lesions are not a life-threatening emergency, the treatment should be delayed until after birth to decrease any chance of causing a spontaneous delivery. If, following birth, the lesions are large and do not regress, the treatment of choice would be surgical excision.

Oral pyogenic granuloma of pregnancy, as with pregnancy gingivitis, is possibly an exaggerated response to local existing irritants brought about by elevated levels of sex hormones. Therefore, the importance of dental hygiene, especially for pregnant women, cannot be overemphasized.

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Phillip J. Hanes, DDS, MS  
Jerry J. Garnick, DDS, MS  
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3. Tarsitano BF, Rollings RE. The pregnant dental patient evaluation and management. *Gen Dent* 1993; 41(3):226-31.

## CHOLESTEROL AND MORTALITY IN OLDER PATIENTS

To the Editor:

I applaud you and the editors for the concept of the JFP Journal Club, enabling busy physicians to get expert commentary on well-designed studies that might change how they practice medicine.

I question, however, Adam Goldstein's one-sided interpretation of the paper by Krumholz and colleagues (*Krumholz HM, Seeman TE, Merrill SS, et al. Lack of association between cholesterol and coronary heart disease morbidity and all-cause mortality in persons older than 70 years. JAMA* 1994; 272:1335-40) that he commented on in the February issue of the *Journal* (page 187). This prospective cohort study with a 35% nonresponse bias from one community in the Northeast showed no association between 4-year total mortality and coronary heart disease mortality. This study should be assessed in the context of the Framingham, Honolulu, and Rancho Bernardo cohort heart studies, which have shown an association between total cholesterol and coronary heart disease in the elderly.

A randomized clinical trial in the elderly, the ALHAT trial, that is being performed by the National Institutes of Health should give better evidence to answer this important question in the next 5 years. In the interim, definitive statements regarding cholesterol in the elderly based on one longitudinal study are premature and potentially harmful to the health of elderly patients. I look forward to more circumspect recommendations for clinical practice in the future.

Charles B. Eaton, MD, MSc  
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The preceding letter was referred to Dr Goldstein, who responds as follows:

I appreciate Dr Eaton's correspondence and concerns, which allows for a more complete response to an important clinical question: Should physicians routinely screen asymptomatic patients over the age of 70 for high cholesterol levels? To date, the bulk of evidence cited in this response suggests caution at best in proceeding with cholesterol screening in this population, recognizing that there is a real possibility that such screening may



provide no net benefit, or a very small one, or may, in fact, be harmful.

The New Haven cohort described in my review in *The Journal*<sup>1</sup> clearly showed that cholesterol screening in asymptomatic men and women over the age of 70 (mean age = 79) did not predict coronary artery death or disease or all-cause mortality. This was a longitudinal, prospective cohort study in which <1% of participants were lost to follow-up and subjects' outcomes were thoroughly documented.

In Rancho Bernardo, California, total plasma cholesterol levels were associated with fatal coronary artery disease deaths in men but not women.<sup>2</sup> There was no reduction in overall mortality. More important, however, low cholesterol levels in this population of men were three times more likely to be associated with clinical depression.<sup>3</sup> In the Los Angeles Veterans Administration study, low cholesterol diets used by a cohort with high cholesterol levels also led to a reduction in both cholesterol and coronary heart disease in men with a mean age of 66, but there was an increase in cancer mortality as well as overall mortality in the intervention group.<sup>4</sup>

The Honolulu heart study also found that elevated serum cholesterol values in men over age 65 predicted coronary heart disease mortality, but not total mortality.<sup>5</sup> Moreover, the authors of the original study have published more recent research from this same population that shows if a population-based approach is taken to lowering cholesterol levels for elderly patients with only modest elevations in cholesterol values, there may be a 60% increase in overall mortality.<sup>6</sup> Isolated risk-factor readings taken in the elderly may not relate to lifetime risks since many elderly patients with risk factors for heart disease (elevated blood pressure, cholesterol, body mass index, etc) had normal values when screened years previously.<sup>7</sup>

In contrast to the Rancho Bernardo and Honolulu studies, the Framingham study<sup>8</sup> showed that elevated cholesterol levels were associated with coronary heart disease in women older than 65 years, but not men. Low cholesterol levels in the Framingham cohort, however, were associated with higher noncardiac mortality over a wide variety of ages.<sup>9</sup> There is also evidence from other studies that elderly women with higher cholesterol levels have lower overall mortality rates, and that low cholesterol levels are inversely associated with longer life.<sup>10</sup>

Many asymptomatic elderly patients take cholesterol-lowering medications, most of which are costly or have unpleasant or serious side effects. Even if medication did lower the risk of some elderly patients' getting coronary artery disease, clinicians must be honest with their patients in reporting that multiple longitudinal trials of lipid-lowering medications used in younger patients have shown no overall reduction in mortality.

The results from the ALHAT trial mentioned by Dr Eaton will be a welcome addition, but they will not be available for at least 7 more years. Until that time, we must remember that cholesterol screening has many costs, including those associated with the test, counseling about the test, repeated testing, physician time, dietary modification, costs of pharmaceutical medications, side effects of those medications, and labeling phenomena. In order to advocate for cholesterol screening, the benefits of screening must clearly outweigh the risks, and the data must convincingly show improved outcomes. The failure of cholesterol screening in asymptomatic elderly men and women to meet both criteria sufficiently at this time weighs against its routine incorporation into patient care.

Adam O. Goldstein, MD  
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## SPONTANEOUS TMJ DISLOCATION

To the Editor:

I enjoyed reading your article on spontaneous temporomandibular joint dislocation in an 80-year-old man (*Smally AJ, DelGross C. Spontaneous temporomandibular joint dislocation in an 80-year-old man. J Fam Practice* 1995; 40:395–8). You found him to be the oldest person in the English language literature with such a problem.

Approximately 1 year ago, a female patient of mine who was 82 years old at the time had a spontaneous TMJ dislocation. She was on a pureed diet and had not verbalized in several years. She was found in this condition without signs of trauma, and no etiology was found.

She was easily reduced by manual pressure with premedication of 2 mg of midazolam hydrochloride IV. No further dislocations occurred. Perhaps this problem is more frequent in the elderly than is reported.

Dharma K. Khalsa, MD  
Albuquerque, NM

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

Dr Khalsa raises two interesting points. One must first ask if the dislocation of this patient was truly a spontaneous dislocation. In either a home or a nursing home environment, one must consider the possibility of abuse. In the event that previous injuries, other history, etc, does not make one suspicious of "elderly abuse," then the spontaneous dislocation probably resulted from yawning.

In my career, I have treated probably 15 to 25 jaw dislocations, and the great majority of patients were in the 20 to 40 age group. My interest was thus aroused



when this patient's advanced age was associated with a diagnosis that I previously had considered that of much younger people. I conducted a literature search and discovered two things: one, this was the oldest patient, and two, other patients nearly as old had been reported. In addition, though, I noted that there was no recent article on the treatment of jaw dislocations in the family practice literature. For these reasons, we wrote up the case report and discussion of the treatment of this condition.

I think the medical literature would be improved if more general nonacademic physicians undertook publication of interesting cases. Having successfully done this as a rural family physician in Colorado, I can assure the readers of the *Journal* that it can be done.

A. J. Smally, MD  
Hartford Hospital  
Hartford, Connecticut

## ASTHMA ATTACK TRIGGERED BY BARBECUE

To the Editor:

We enjoyed the "Pearls" in recent issues. Here is another tip, especially useful in the summer months: ask asthmatic patients if they barbecue food. We have seen two patients on consecutive days who had asthma attacks triggered by barbecue smoke at family cookouts.

Susan Hoppe  
First-Year Medical Student, UCLA  
C. Victor Wylie, MD  
CIGNA Healthcare of California  
Los Angeles, California

## COST-EFFECTIVENESS IN MEDICINE

To the Editor:

We are currently spending about 1 trillion dollars annually for medical care in America. Therefore, cost-effectiveness in medicine is the order of the day, from Washington to the smallest rural town.

I believe that any discussion of cost-effectiveness must take into consideration the following principles:

1. The concept of efficiency can be misleading and, when motivated by greed, will not enhance cost-effectiveness. There is evidence

that in certain systems of Managed Care, money is simply being redistributed. There are winners (administrators, managers) and losers (physicians, hospital workers), but the economic mess in medicine will remain the same until ethics, not profits, becomes the first consideration. There is no justification for certain CEOs to reap millions in salary and stocks in a system of care that denies access to an estimated 39 million patients.

2. There is good medicine and there is defensive medicine, but there is no such thing as good defensive medicine. As long as physicians are pressured to order unnecessary tests and treatments to please uninformed consumers or peer reviewers, to seek economic gains, or to psychologically ward off the fear of potential malpractice suits, cost-effectiveness cannot be achieved. It is crucial that caregivers be compensated for spending quality time with patients. In primary care medicine, the quality of care has much more to do with sharing information, coaching, supervising, even role modeling, than with intervening and treating.
3. Despite all the technological advances and the abundance of drugs, medicine is still an art, not an exact science. In many ways, the high costs of medicine are the direct result of the elusive effort to prove all pathological processes with hard physical evidence, as conceived in western medicine. The art of healing requires more than the ability to demonstrate physical evidence. It requires a certain sensitivity, a sense of intuition that can be neither visualized nor palpated. Pain, the cardinal medical symptom, for instance, has a subjective element that cannot be measured by physical indicators. In the climate of fascination with physical evidence, the common mistake is to treat patients as "specimens" rather than whole human beings.
4. The emphasis on teaching how to diagnose serious or rare diseases,

and finding cures for them, should be balanced with the reality that most patients do not have serious or rare diseases and that most diseases do not have a cure. Many medical conditions are preventable. For the patient with chronic disease, eg, rheumatoid arthritis, diabetes mellitus, hypertension, or a fatal illness, eg, incurable cancer or leukemia, medicine does not offer miraculous cures, but rather provides palliative and supportive care. In these situations, helping the patients cope with their illnesses is more cost-effective than venturing into futile diagnostic and therapeutic procedures.

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Millpitas, California

## CORRECTION

In the June issue of the *Journal* (pages 540-1), three citations were inadvertently deleted from a letter to the editor by Dr. Saeed Ahmad entitled "Drug Interaction Induces Hypoglycemia." The following is a reprint of part of the final paragraph with the missing citations and their corresponding references:

Other drugs described as having interacted with enalapril include indomethacin,<sup>6</sup> other nonsteroidal anti-inflammatory agents, and lithium.<sup>7</sup> There is a case report in which the patient developed anaphylaxis and severe coronary spasm, culminating in acute myocardial infarction, owing to concomitant administration of enalapril and allopurinol.<sup>8</sup> In view of this clinical observation, I suggest that glyburide enalapril interaction also be added to this list.

Saeed Ahmad, MD  
Fairmont, West Virginia

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