LETTERS TO THE EDITOR

MOUNTAIN BIKE INJURY

To the Editor:
The article by Rivara and associates[1] on off-road cycling injuries that appeared in the May issue of the *Journal* was timely and informative. We agree with the authors' conclusions about the unique challenges this relatively new sport presents to family physicians.

We report a case of an atypical injury that occurred from a mountain bicycle fall, highlighting the unique characteristics of these accidents. A 33-year-old man presented to our clinic 2 days after falling head-first over the handlebars of his mountain bicycle. He was traveling on a rugged path with a mild downgrade at a speed he described as moderate. The fall resulted in no loss of consciousness, and the helmet remained intact. He complained of posterior neck pain at the level of his shoulders. Examination revealed tenderness of the trapezius muscle and difficulty fully extending the neck because of pain. His general physical and neurologic examinations were otherwise normal.

Cervical spine radiographs were clear through C7. Thoracic spine films, however, revealed a wedge-shaped fracture of the T1 vertebral body. The fracture was best appreciated on the lateral view of the cervical series, which showed T1 very well (Figure 1). Computed tomography confirmed the "tear drop" fracture of the anterior superior aspect of T1 (Figure 2). Orthopedic consultation was obtained, the patient was placed in a thoraco-lumbar brace for 4 weeks, and recovery was complete.

FIGURE 2

Computed tomography image through the T1 vertebral level.

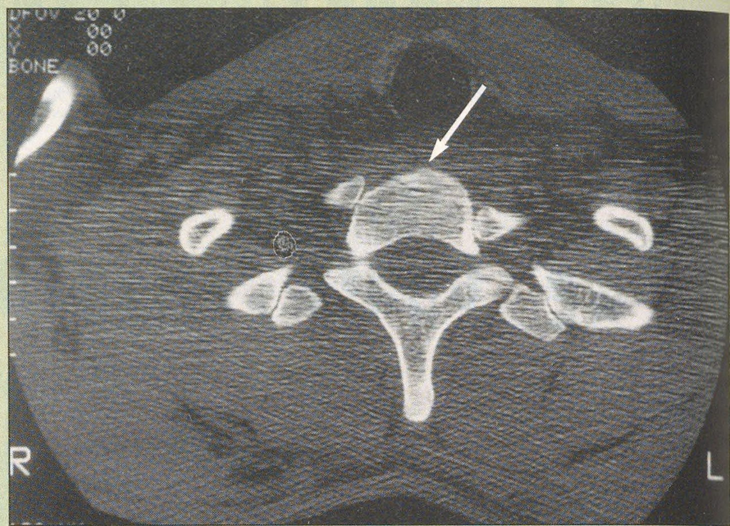
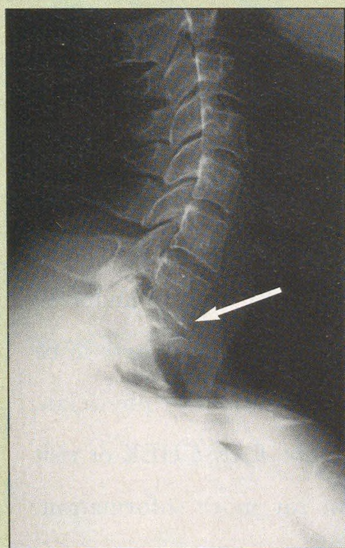


FIGURE 1

Lateral cervical spine radiograph.



As presented in the article by Rivara et al,[1] mountain bicycling differs from traditional bicycling in several important ways. Similarly, Kronisch et al[2] described this unique pattern of injuries seen in mountain bicyclists. They also concluded that most injuries tended to be minor, but compared with traditional bicycling, mountain bicycle injuries could easily be more severe and more likely to result in fracture, and were much more likely to be associated with unfamiliar and difficult terrain, high-speed descent, and loss of control. Injury sites were generally similar, with mountain bicycle injuries yielding more extremity trauma. Of note, thoracic vertebral injuries were not reported.

Accurate diagnosis of injuries relies on the history and mechanism of injury. Although routine radiological survey has not been shown to be cost-effective, plain films can provide valuable information about injury sites with focal findings. ATLS recommendations[3] include the cervical

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spine series.

The lesion described in this case is remarkable in that the fracture occurred distal to the spine. We speculate that this may have occurred as a result of an unusual body position while falling in off-road terrain. The weight of the rider likely produced axial-load forces high enough to effect a fracture in such an elusive site. Moreover, inexperience of the rider in falling and the unfamiliar rough terrain were likely contributing factors. Interestingly, the helmet remained intact, suggesting that the amount of energy absorbed by the helmet was insufficient to cause breakage, and the amount absorbed by his body was proportionately higher.

While our experience with this one case can only be interpreted as anecdotal, it underscores the need for appropriate safety equipment, and also supports the opinion that *both* cervical and thoracic spine plain films should be considered when evaluating an injured mountain bicyclist following an axial-load type injury.

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MANUSCRIPT SUBMISSION TO
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ABORTION PROCEDURE

To the Editor:

The lead article in the April 1997 *Journal* contains not a word of moral reservation about abortion *(Schaff EA, Stadalius LS, Eisinger SH, Franks P. Vaginal misoprostol administered at home after mifepristone (RU486) for abortion. J Fam Pract 1997; 44:353-60)*. Nor is any expressed by the *Journal's* editor or the editorial board, who gave it top billing. Acknowledgments include Larry Lader, President of the Abortion Rights Mobilization, thanking him "for his dedication in bringing mifepristone to the United States. . . ."

Increasingly, the relevant division is between those who recognize God and His Word and those who ignore Him, especially academic "ethicists," who endlessly quote each other. As history has taught with the other great holocaust of this century, neutrality is complicity. Your editorial stance condones and promotes, and thus encourages the taking of innocent human life.

A. Patrick Schneider II, MD, MPH
Lexington, Kentucky

To the Editor:

Drs Schaff et al virtually celebrate "a promising alternative to surgical abortion." Does the *Journal's* editorial staff possess the recognition to grasp what this article represents? Does the reading audience realize how far we have come from the Hippocratic oath (ie, the ancient, unabridged form which states, "I will not give to a woman an instrument to produce abortion")? Does anyone perceive how far we are from straying from the ethical practice of medicine that has historically been based on concepts of healing and the utmost respect for human life?

Publication of this article by the *Journal* is indicative of the moral debasement of our contemporary culture. And as members of that culture, family physicians are now, one may conclude, supposed to cheer this "new" method of prescribing the execution of innocent, defenseless human life (and all in the convenient privacy of the mother's own home). In these days of partial-birth abortions, of creeping Kervorkianism, and of RU486 possibly soon to be available for every home, we are being entreated to sign on as practitioners of killing, or at the very least to countenance others who so enlist.

With all that is within me, I appeal to my professional colleagues: May our consciences yet be resurrected from the dead!

James L. Fletcher, Jr, MD
Cape Girardeau, Missouri

To the Editor:

I wish to express my displeasure regarding the article in the April issue of the *Journal* on vaginal misoprostol administration at home following mifepristone for the purpose of abortion of pregnancy. It would seem as though one were reading about a better treatment for acne or halitosis, judging from the sterile and banal manner that Dr Schaff et al portrayed this pharmacologic assault. I would like to say I was shocked by this but, sadly, I am becoming used to physicians' abandoning the ethical heritage of medical practice.

The article has as its basis several premises that I consider invalid, rendering it unfit for publication in a credible journal of medicine. First, Schaff presumes the acceptability of moral neutrality in physicians. A morally inert physician is simply a businessman, having compromised

his credibility and undermined his professional character. I believe this ill represents our profession, still upheld as noble by most of us, and has done much to cast medicine into public disfavor.

Second, the article presumes that the reader accepts that the humanity of the unborn is determined solely on the mother's willingness to be pregnant. From this position, it follows that if the baby is wanted by the mother, the fetus is a human being and therefore also a patient of the physician. If not wanted, the conceptus is not really a baby, which is a human identity, but simply a parasitic tumor to be removed in the service of the woman, not really a mother, who is then the only patient. Where else in the practice of medicine is this kind of rationale valid?

Finally, I disagree that it is the role of a physician to interfere with a state of health. Uncomplicated pregnancy is no disease state and abortion certainly is not "health care." Even those physicians who have forfeited the medical profession in favor of becoming a "health care provider," a business-imposed title, have little justification for this behavior, which is simply murder in a white coat.

I submit that this article belongs in a journal of experimental veterinary pharmacology, not a journal of medicine, much less of family practice. But then, a study of this type would likely have difficulty passing the veterinary journal's ethics committee.

MAJ Paul Casner, MC,USA
Fort Polk, Louisiana

To the Editor:
Your selection of the article on vaginal misoprostol for the April issue of the *Journal* evokes a great deal of sadness. In part, this is due to the fact that the study originated from the residency program I trained at many years ago. Mostly it brings home again the message of the moral and ethical decay in our profession, indeed in our country.

From here, this article demonstrates the truism one more painful time, that progress without a moral rudder is dangerous. As family physicians, we come from a long heritage of "firstly, do no harm," of life- and health-preservation principles. Our entry into the arena of death through abortion counseling and medical and surgical abortion procurement has inevitably led us to mercy killing. God only knows what is next.

And may He have mercy on us all.

Greg A. Gehred, MD
Fort Atkinson, Wisconsin

The preceding letters were referred to Drs Eisinger, Schaff, and Franks, and Lisa Stadalius, RNC, who respond as follows:

Drs Casner, Fletcher, Schneider, and Gehred apparently have strong anti-abortion opinions. We are offended by their tone of moral superiority based on their personal religious beliefs that allow them to judge the women who seek abortions and the physicians who care for them. Caring and religious women have abortions and competent and ethical physicians provide this health service.

Abortion is the most common surgical procedure in the United States. According to the World Health Organization, more than 200,000 maternal deaths result worldwide from illegal and unsafe procedures. The number of procedures and morbidity warrants additional study. Women should receive the safest medical care possible with dignity.

To ensure quality and increase the dwindling pool of abortion providers, we are pleased to announce to the *Journal*'s readership the University of Rochester's first national Medical Abortion Conference for Primary Care Clinicians to be held in Rochester, NY, December 12 and 13, 1997.

Steven H. Eisinger, MD
Eric A. Schaff, MD
Lisa S. Stadalius, RNC, MS
Peter Franks, MD
University of Rochester
Rochester, New York

EDITOR'S NOTE: I appreciate the strong and sincere feelings expressed by Drs Schneider, Fletcher, Casner, and Gehred, and am pleased to be able to publish their letters in their entirety.

The mission of *The Journal of Family Practice* is to provide the practicing and research communities of family physicians with a broad range of scholarly work in all aspects of our discipline. The *Journal* is carefully designed to support further development of the science base of family practice through original research and critical review of available evidence in important clinical areas.

My decision to publish the study by Schaff et al was based on the quality of the science presented by the authors on an important topic in family practice. A decision to withhold publication of the study because of the legitimate objection of some in family practice would have been, in my opinion, a serious violation of the mission of the *Journal*.

Paul A. Nutting, MD, MSPH

POST-VASECTOMY ORCHITIS

To the Editor:
I read Dr Reynolds' letter in the April issue of the *Journal* with great interest and offer the following comments *(Reynolds JL. Venting for post-vasectomy orchitis. J Fam Pract 1997; 44:329)*.

After many years of doing a vasectomy with two incisioins, excising a segment, cauterizing or tying both ends, covering the proximal end with fascia, and then suturing the skin, I

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switched to the "no-scalpel vasectomy" and leave the distal end open. This procedure is easier for me and, therefore, the patient.

Leaving the distal end open probably does not prevent or treat "obstructive orchitis"; it merely lets the sperm drain into the scrotum.

It sounds to me as though Dr Reynolds' patient had engorgement (passive congestion) of the testicle and not obstructive orchitis. An orgasm would probably have relieved him immediately. The occasional patient of mine who complains of testicular pain postoperatively is always relieved promptly by orgasm.

Many physicians who do vasectomies advise their patients to avoid intercourse and ejaculations postoperatively for a week or more. I have never advised abstinence and have heard of no problems when sex was performed. In fact, if not told to abstain, most patients will "try to see if it works" that night and have no ill effects. They probably prevent what Dr Reynolds' patient was suffering.

Roy G. Gravesen, MD
Johns Hopkins Medical Services Corporation
Baltimore, Maryland

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

Dr Gravesen offers some intriguing thoughts on the avoidance of post-vasectomy orchitis. While I agree that the no-scalpel method is much less traumatic than the old scalpel method, I doubt whether men should attempt to have intercourse the night immediately after the procedure.

The evidence supports Dr Gravesen's practice of leaving the testicular end of the vas open as an effective method of reducing post-vasectomy testicular pain (orchitis).[1,2] In the case I reported, I am doubtful that the patient described could have achieved an orgasm because of his severe pain and associated swelling. It seems unclear how an orgasm would relieve an obstructed testicle when the cause of the obstruction is occlusion of the vas? This was precisely the point of my letter. If the pain is due to obstruction of the testicle because of occlusion of the vas, venting the vas may reduce pain and associated symptoms. It was successful in my patient. Others may consider its use in selected cases.

J. L. Reynolds, MD, MSc, CCFP
London, Ontario

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