

LETTERS TO THE EDITOR

GERIATRIC FUNCTIONAL ASSESSMENT

To the Editor:

Caring for the older adult is an increasingly important component of daily medical practice as a result of demographic changes in the US population. Clinicians regularly perform a "review of systems" to look for pathophysiological disorders and disease. However, a "review of functions" is not regularly performed, and as a result, functional disabilities may remain undetected. Functional disabilities for elderly patients are sometimes a more important problem in everyday life than the chronic disease or medical conditions that brought about the functional limitations.^{1,4}

Assessment scales have been developed and validated for evaluation of key areas of function in older adults; however, they are not widely used in primary care because of time constraints, poor reimbursement, or the belief that clinical judgment by the physician is as effective as the assessment tools.^{1,5,6} The common goals for the use of assessment instruments in clinical medicine include establishing a baseline description, screening for risk factors or undetected problems, assisting in diagnosis, setting therapeutic goals, and monitoring the patient's clinical course.^{7,8}

We performed a study to determine if an informal assessment of functional status based on prior knowledge of the patient by the primary care physician agrees with the patient-reported functional assessment. The physician was a family practice physician with a Certificate

TABLE

Prevalence of Functional Impairment as Determined by FASE Compared with Perceived Impairment by Primary Care Physician

Functional Areas	No. (%) Impaired Patients	No. (%) of Unimpaired Patients	Reported Sensitivity (%)*	Reported Specificity (%)*
Telephone use	2 (5)	38 (95)	100	95
Shopping	12 (30)	28 (70)	58	96
Meal preparation	4 (10)	36 (90)	50	97
Dressing, washing, and toilet use	1 (2)	39 (98)	100	97
Getting to places	8 (20)	32 (80)	50	94
Taking medications	1 (2)	39 (98)	100	95
Money management	9 (23)	31 (77)	33	97

*Reported by primary care physician.

FASE denotes Functional Assessment Screening Evaluation.

of Added Qualification in Geriatrics. Fifty patients were randomly selected from a list of Medicare Risk patients assigned to this family practice physician. The primary care physician scored the patient using the Functional Assessment Screening Evaluation (FASE) and was blinded to the result of the telephone assessment. The investigator then conducted a telephone interview using the FASE instrument. This instrument evaluated the activities of daily living, which included bathing, dressing, toileting, and ambulation. It also evaluated the instrumental activities of daily living, including using the telephone, shopping, preparing meals, taking medications, and managing money. Of the 50 patients randomly selected, 40 patients responded and were included in the study. Of the 10 patients excluded, 3 have not seen the primary care physician at all, 5 were never reached, 1 refused to participate, and

1 died 1 week prior to the call.

The results detailed in the Table show a 95% agreement on finding or not finding a problem with telephone use, dressing, washing and toileting, and taking medications; lowest agreement and therefore highest disagreement was seen in the areas of money management followed by shopping and ability to get places. The overall result showed that 14 (35%) of the 40 screened patients reported at least one impairment. This implied impairment of function to a certain degree, and therefore requires a more in-depth functional assessment.

Functional assessment screening is useful in identifying elderly patients with impaired function. The major advantage of a screening instrument is its simplicity, ease of use, and minimal time commitment. Patients identified as having functional impairment should undergo a more in-depth functional assessment to enhance patient care for seniors.

Anita Mercado, MD
James Meza, MD, MSA
Lois Lamerato, MS
St Clair Shores, Michigan

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PRIMARY CARE INSTRUMENT

To the Editor:

There has been considerable interest in the Components of Primary Care Instrument (CPCI) for different applications in research and evaluation since the paper describing the instrument development was published.¹ The CPCI scale scores have been previously found to be associated with patient satisfaction¹ and preventive services delivery.² The CPCI can also be used to assess the potential harmful or beneficial side effects of interventions on the core domains of primary care. And, finally, the CPCI scale scores may be used as outcome measures themselves. For example, the CPCI scale scores have been found to be negatively associated with disruption in the patient-physician relationship.³

A revised version of the CPCI has been generated since the paper describing its development was published. The revision is printed on a single sheet (2 sides) and takes patients about 15 minutes to complete.

Readers wishing to obtain a copy may contact me at the Department of Family Medicine, Case Western Reserve University, 1101 Cedar Road OCRC 2, Room 306, Cleveland, OH 44106-7136; phone: (216) 368-3887; fax: (216) 368-4348.

Susan A. Flocke, PhD
Case Western Reserve University
Cleveland, Ohio

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BACTERIAL PHARYNGITIS IN CHILDREN

To the Editor:

Family physicians commonly see children who present with fever, tonsillar exudate, and pharyngeal inflammation. We may choose to treat such children with antibiotics even if a rapid test for group A *Streptococcus pyogenes* is negative, recognizing that the patient's illness may be caused by bacteria other than group A streptococci; for example, *Staphylococcus aureus*, corynebacteria, or *Haemophilus influenzae*. For such patients, an antibiotic that covers both streptococcal and nonstreptococcal causes of bacterial pharyngitis would be preferable.

Clarithromycin (Biaxin) is marketed as an antibiotic that provides good coverage for streptococci while also covering nonstreptococ-

cal causes of bacterial pharyngitis. To date there have been no published report of any case in which clarithromycin failed to treat a case of group A streptococcal pharyngitis. I am writing to report such a case.

A 10-year-old boy weighing 40 kg presented with a 24-hour history of low-grade fever (100.4°F) and sore throat. On examination, the pharynx was red. The tonsils were small and free of exudate. No test for streptococci was performed. Clarithromycin 250 bid for 10 days was prescribed. The next day the patient returned complaining of a more severe sore throat. His temperature was now 103.2°F. On examination, the throat was more intensely red and a small amount of thick green exudate was visible on the tonsils. A rapid test for group A streptococci was strongly positive. The patient was instructed to discontinue clarithromycin and begin amoxicillin/clavulanate potassium (Augmentin) 400 bid for 10 days. The patient experienced dramatic and complete relief of all symptoms within 24 hours.

A MEDLINE search using the key words "streptococcal" or "streptococcus" and "clarithromycin" revealed only a single report of group A streptococci resistant to clarithromycin.¹ This report documented in vitro resistance of some group A streptococci isolates to clarithromycin. I was unable to locate any report of failure of clarithromycin to treat group A streptococcal infection in vivo. Physicians must recognize that at this time there is no one antibiotic which can reliably cover all organisms that can give rise to bacterial pharyngitis in children.

Leonard Sax, MD, PhD
Poolesville, Maryland

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