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PERIODIC HEALTH EXAMINATIONS
AND DELIVERY OF CANCER
PREVENTION SERVICES

DOCTOR-PATIENT COMMUNICATIONS

MODIFIABLE HIGH-RISK BEHAVIORS
FOR CARDIOVASCULAR DISEASE AMONG
FAMILY PHYSICIANS

THE ELECTRONIC HOUSE CALL

DICLOFENAC IN LATERAL EPICONDYLITIS
OF THE ELBOW ALSO TREATED
WITH IMMOBILIZATION

THE DEPARTMENT WITHOUT WALLS

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The nature of the interventions used by primary care physicians leads to my second observation. The researchers would seem to have been generous in giving "credit" for counseling when as little as 3 minutes of supportive, problem-based counseling was provided. Yet, I am frequently struck by the apparent positive influence such limited counseling can have, at least as attested by the profuse gratitude expressed by many patients. I take this gratitude not to mean that my words have some particular curative power, but rather that the symbolic importance of taking what is actually a notable portion of a short visit to validate the importance of their anxious or depressive symptoms can lead to other curative behaviors, including medication compliance and referral.

The third finding worth noting is that patients who were anxious were more likely to receive treatment when depression was present as well, suggesting again that primary care physicians are responding to the total presentation of distress and dysfunction, regardless of their formal recognition of criterion-based diagnoses. On the other hand, they may also be responding to the severity and nature of symptoms and inappropriately treating distress rather than a treatable disorder. This study finding is the one that generates the most curiosity and seems to beg for further study, perhaps using richer data on fewer patients and physicians so that we might learn why physicians choose certain cues to respond to and how they respond to the cues they choose.

My final reaction concerns the interspecialty differences in treatment. The likely reason that patients who have anxiety disorders superimposed on chronic medical illnesses are more likely to receive treatment from consultants than from primary care physicians is that they are simply a different sort of patient, because of the funneling effect of patients who receive care from specialists through physician or self-referral. On the other hand, specialists also have the luxury of spending more time with the patient, during which they may respond to subtle behavioral cues that go undetected in the brief encounters with generalists. It is this latter reason that leads me to frequently advise residents and students to not feel in a hurry to reach closure with a patient who has vague symptoms, seems to be in distress, or who has stigma of psychiatric illness. One or 2 early follow-up visits, during which more questions can be asked and more nonverbal behavior assessed, can lead to a much different picture of a perplexing and complex problem.

This snapshot of the way general medical patients with anxiety disorders receive care and the type of care they receive seems to fit with my personal experience, but raises several questions that cannot be answered with this methodology. Unfortunately, many financial and organizational questions are being answered with data of this type and there seems to be little support or enthusiasm by funding agencies to dig into the "messy" world of comorbidity in primary care. Unlike with the toddler's toy, one cannot simply look underneath to see how the "little creatures" are connected and why they pop up in the order they do. Until we understand how these pesky problems pop up and learn what sort of mallet we need to whack them effectively back down, we will continue to flail away at competing medical priorities as best we can.5

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REFERENCES


Clinical Pearl

For patients with heart valve replacements already receiving warfarin sodium, adding aspirin (100 mg/d) was associated with a lower rate of major systemic embolism and death but more major bleeds and bleeding episodes. (N Engl J Med. 1993;329:524-529.)
and coping. Stress was often produced when a conflict in values existed between the person and the work environment. When medical decisions were based on criteria set by the insurance company—rather than quality patient care, and the choices were dictated by nonphysicians—caring and control were undermined.

Stress was also created if values became manifested in unhealthy extreme ways. In patient care, phrases such as “make everyone happy” and “do it all myself” reflected an overly caring style that eventually contributed to heightened stress. The difficulties of participants with extreme caring could be related to the “well-liked” criterion of health as defined by the knowledgeable informant.

A few findings of this study were surprising. The first is the presentation of spirituality as a value and prayer as a coping strategy. Minimal attention has been directed toward spirituality in previous research on physician stress. This dimension was presented early in the interview process, reflecting its importance.

A second surprising finding concerned the level of emotionality in the interviews. There were many moments in which intense feelings were strongly expressed. This was quite different from my expectation of caution and guardedness. It could be argued that the openness of the participants was tied to their psychological health. My membership on the family medicine faculty and career as a mental health professional familiar with the culture of family medicine could also help explain this quality.

A potential limitation of this study is its reliance on interviews as the main source of research data. Subjective bias can be viewed as a possible confounding factor in interview-based studies. In this study, maximum variation sampling, identification of the sample by a knowledgeable informant, peer reviewing, and a member check procedure were qualitative strategies used to increase the credibility of the study.

Future research should expand on the directions initiated by this study. First, substantially more research should be directed toward healthy and satisfied physicians. Focusing on this group can facilitate the creation of positive solutions to the stress-related difficulties inherent to the practice of medicine.

Closer attention to developmental processes would also enrich the quality of research on physician stress. Quantitative methods tend to restrict data to the specific point of time when inventories are completed, limiting the data to one specific time in the life of the research participant. The methods of this study allowed the physicians to present meaningful developmental information to be explored in future research efforts.

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Six problem-solving counseling sessions improved depressed patients as much as amitriptyline hydrochloride and more than placebo. (BMJ. 1995;310:441-445.)
between the 2 treatment groups, 3 months after the end of the trial. Finally, we have no explanation for the higher frequency of abdominal pain and diarrhea in the experimental group. It is not known if this effect is dose-related since a single dosage was used for all patients in this trial, as suggested by the manufacturer.

CONCLUSIONS

A number of interesting conclusions can be drawn from this trial that has studied the benefits of diclofenac over rest and immobilization in the treatment of tennis elbow: (1) Diclofenac produces a significant reduction in pain when compared with a placebo. (2) Diclofenac does not produce a clinically significant improvement of grip strength or function of the involved upper limb when compared with a placebo. (3) Diclofenac does not significantly decrease the number of days missed at work, 3 months after the end of treatment. (4) There is a time-related significant improvement in pain, grip strength, and function of the upper limb that is independent of the treatment received. This improvement can only be explained in 3 ways: it can be due to a placebo effect, to cast immobilization and rest, or to the natural history of the disorder associated with rest.

Based on these findings and on the number of side effects noted during the trial, we do not recommend the use of diclofenac in the treatment of LE at the dosage prescribed in this trial. Use of a smaller dose may be worthwhile to provide analgesia in LE, but not for functional improvement. Finally, we strongly suggest the pursuit of other clinical evaluative studies on the currently used different treatments of LE.

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We thank Ciba-Geigy Canada, Montreal, Quebec, for providing the medication (active and placebo) and for supporting the data collection. We also thank Hélène Montpetit for secretarial support.

REFERENCES


Clinical Pearl

Vitamin E supplements were associated with decreased progression of known heart disease for those patients receiving other lipid-lowering therapy (P=.02). (JAMA. 1995;273:1849-1854.)
flammmation may not always be a significant component in lateral epicondylitis, many acute injuries do have significant inflammation and show notable improvement with repeated applications of ice to the injured area.\(^6\) Heat may also be of benefit when it is applied in chronic musculoskeletal conditions in which stiffness or soreness are the primary complaints.\(^7\)

I applaud the pharmaceutical researchers and companies for continuing to add to our choices of treatments with medicines that offer more and more advantages, and I would certainly not want to discourage their continuing research efforts, progress, and discoveries. I encourage all primary care physicians to consider the addition of these new agents to their list of treatment options, but in their appropriate place as indicated by applicable scientific research. However, even with the newest and “flashiest” pharmaceutical drugs, don’t forget and ignore older but established therapies. The 2 therapies should be complementary, using the “older” regimens as indicated and when cost-effective, but including the “newer” treatments and medications when there is lack of progress, greater effectiveness is seen, higher patient compliance is needed with longer dosing intervals, or long-term cost-effectiveness is improved by reduced medication cost or by preventing more expensive therapies or surgery. But don’t forget—the best treatment may sometimes already be “sitting in the back of your medicine cabinet.” Mother sometimes did know best.

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REFERENCES


Clinical Pearl

Many men who snore more than half the night do not have sleep apnea. (Am J Respir Crit Care Med. 1995;151:1459-1465.)

Weight loss (≥3 kg) improved snoring. A weight loss of 6 to 11 kg stopped snoring for a few men. (Chest. 1995;107:1283-1288.)
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24. Internet distributes child porn from an address in Helsinki. Helsingin Sanomat February 7, 1995;1.


Clinical Pearl

Erythromycin (250 mg 3 times daily for 3 weeks) was associated with faster gastric emptying time and lower symptom score than metoclopramide hydrochloride (10 mg 3 times daily). (Diabetes Care. 1993;16:1511-1514.)
Physicians are in a position to provide the information and education required to help limit the transmission of HIV. Primary care physicians should inquire about HIV risk factors (by obtaining a complete sexual history, a history of sexually transmitted diseases, information about sexual orientation, a history of intravenous drug use, and a history of blood transfusions) in all patients, regardless of age, and should counsel patients about effective HIV prevention strategies.

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application developed from their desire to give nurses an effective way to interact with infants and families in an educational and interventional manner in the early postpartum period. Munck addresses the strength of the NBAS as a psychotherapeutic approach in the face of a particularly vulnerable parent-child unit. Her clinical vignettes demonstrate the value of interpreting an infant's behavior for a parent and of demonstrating the infant's innate strengths. She shows parents ways to recognize signs of stress in their infant and to decrease the environmental toll on their vulnerable child. Cardone and Gilkerson describe a specialized adaptation of the scale called “Family Administered Neonatal Activities.” Their goal is to empower families in their model; the parents are instructed by a facilitator to perform the NBAS items and to comment on and interpret their observations of their infant and themselves. This information is reflected and interpreted by the facilitator in an instructive and therapeutic manner. Cole addresses the use of the NBAS with high-risk neonates. Such infants are accurately perceived as more fragile and less accessible by their caregivers and their families. This application sensitizes parents and caregivers to infants' cues, to their tolerance levels, and to an appreciation of their neurophysiological progress.

Thus, the Neonatal Behavioral Assessment Scale, Third Edition, is a manual that includes rigorous research methods and a wide variety of clinical applications. Addressing the entire spectrum in this compact volume effectively gives the primary care clinician information at whatever depth is desired, from the most precise guidelines for test administration and scoring, to the philosophy and many clinical uses of the scale. The narrative descriptions of the test and the many sections on clinical applications and case vignettes are informative and compelling. I highly recommend this book to any member of a health care team who routinely works with neonates and families. It provides a concise, well-organized, accessible clinical tool for enhancing the counseling of normal and at-risk newborns and their families and will greatly increase the practitioner's appreciation for the complex abilities of the newborn.

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