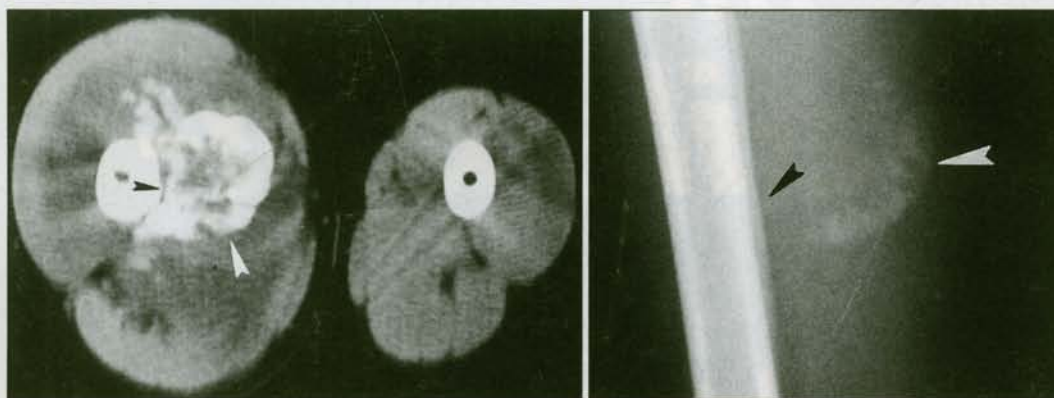


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MANAGING BEHAVIORAL HEALTH CARE
WITHIN THE CONTEXT OF PRIMARY CARE

THE INJURED SHOULDER

THE 'USUAL CARE' OF MAJOR DEPRESSION
IN PRIMARY CARE PRACTICE

ISOLATED DILATED PUPIL

CHANGE IN RISK FACTOR LEVELS
IN COUPLES FOLLOWING
LIFESTYLE INTERVENTION

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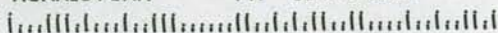
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Inmate Access to Postrelease Medical Care: Public Health Implications

In their 1994 study, Warren et al¹ interviewed inmates who were seropositive for the human immunodeficiency virus (HIV) in a New York City correctional facility during their incarceration and after their release to determine accessibility to medical care services. The authors discovered that HIV-infected inmates were encountering considerable difficulties obtaining postrelease medical care in the community. Of 13 inmates who had been receiving isoniazid prophylaxis during their incarceration, only 1 was able to continue isoniazid prophylaxis after release into the community. The authors warned that such discontinuity of HIV care could potentially lead to active infectious tuberculosis in the community.¹

Two years after their article was published, their prediction has become reality. In 1996, an HIV-infected inmate tested positive to a tuberculin purified protein derivative skin test. Because the results of his previous tuberculin purified protein derivative skin tests had all been negative, he was deemed a recent convertor and administered isoniazid prophylaxis. Three weeks later he was released into the community. However, the correctional facility did not notify the local public health department that this patient was a recent convertor or that he would require continuation of the isoniazid prophylaxis in the community.

Three months after his release, he had a productive cough, fever, night sweats, and weight loss. A chest x-ray film demonstrated a cavitary right upper lobe infiltrate. Acid fast bacilli were demonstrated in smears of sputa; cultures grew *Mycobacterium tuberculosis*.

The risk of active tuberculous disease developing in patients with HIV infection and latent tuberculosis is 7% to 10% per year, which is a relative risk of 113 compared with persons without HIV infection.^{2,3} For HIV-infected patients with latent tuberculosis, isoniazid prophylaxis has documented efficacy in reducing the 2-year risk of developing active disease from 24% to 30% to 4% to 5%.^{4,5} Therefore, HIV-infected patients with latent tuberculous infections should receive prophylaxis as a high priority.

Public health departments must collaborate with correctional primary care providers and administrators to design systems in which inmates have access to postrelease HIV and tuberculosis care. Otherwise, HIV-infected inmates will continue to suffer unnecessary morbidity and communities will be exposed to additional persons with acid fast bacilli smear-positive untreated pulmonary tuberculosis.

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Clinical Pearl

A meta-analysis of oral antibiotic therapy for simple wounds found no benefit. Patients treated with antibiotics actually had a nonsignificantly higher rate of infection (odds ratio, 1.16). (*Am J Emerg Med*. 1995;13:396-400.)

Several potential limitations of this study should be acknowledged. First, women's triage decisions, not unlike ours, were based on limited factual information. Their initial self-reported knowledge about each test was marginal, and they received limited education about the 4 triage tests. Furthermore, these findings reflect the desire of women who for the most part had no experience with these tests. Finally, although factual and standardized, more or less information (positive or negative)¹⁷ about each test and the method of information presentation¹⁸ may have altered the final results.

Regardless of the interim guidelines, many clinicians probably do not offer their patients options for further follow-up of cytologic reports indicating ASCUS and LSIL. A lack of awareness of these guidelines may be one explanation. Simplistic, narrowed triage approaches are also enticing for busy clinicians. However, it may be important to consider patient test preferences when our limited data concerning these tests do not define the best test option. Certain patient characteristics, including age, education, test knowledge, and history are predictive of women's preferences for the evaluation of Papanicolaou smear reports of ASCUS and LSIL. Knowledge of these predictors may be important to consider when counseling women about triage test options. It is important for clinicians to know that otherwise, most women preferred a repeat Papanicolaou smear for a report of ASCUS and colposcopy for a report of LSIL. Women were willing to accept a small risk of not detecting cervical neoplasia if they had a minor cytologic abnormality and, yet, preferred a more accurate triage test for a report of LSIL. Understanding which women prefer certain tests and tailoring approaches accordingly may reduce the high non-compliance rates associated with the follow-up of women with abnormal Papanicolaou smear reports.¹⁹

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time so that we might learn more about their desires about abnormal cervical cytologic reports.

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Editor's Note: This article is about the potential results of using written informed consent for women with Papanicolaou smear results showing atypical squamous cells of undetermined significance and low-grade squamous intraepithelial lesions. It is hoped that all women are informed of their options if their Papanicolaou smears are abnormal. This must be tempered by lack of availability of cervicography, human papillomavirus DNA testing, or both, at many family physician offices.

The content of the information provided to the patient is important. For example, the statement on colposcopy (Figure 2) says it is the "most common procedure done when a Papanicolaou smear indicates precancerous changes of the cervix." With this definition, it is not a surprise that many women chose colposcopy for low-grade squamous intraepithelial lesions when the physician described the condition as "a mild precancerous condition." This despite the fact that the rate of developing more serious cervical disease or possibly cancer is listed as 10% to 15% for low-grade squamous intraepithelial lesions and 5% to 25% for atypical squamous cells of undetermined significance.

I agree with the authors that we as physicians are unsure of the next best test given the limited state of our current knowledge. In these situations, it is all the more important to ask patients for their individual preferences.

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