Scanning the Literature

Lisa Bazzett, MD
Constanza Fox,MD
Paul Marquis, MD

Hormone Replacement Therapy in Women with an "Estrogen Dependant" Gynecologic Malignancy

Suriano KA, McHale M, McLaren CE, et al. Estrogen replacement therapy in endometrial cancer patients: a matched control study. Obstet Gynecol 2001;97:555-560.

Objective: To determine if estrogen replacement therapy, in women with a history of endometrial cancer, increases the risk of recurrence or death from that disease. **Methods:** Two hundred forty-nine women with surgical stage I, II, and III endometrial cancer were treated between 1984 and 1998; 130 received estrogen replacement after their primary cancer treatments and 49% received progesterone in addition to estrogen. Among this cohort, 75 matched treatment-control pairs were identified. The two groups were matched by using decade of age at diagnosis and stage of disease. Both groups were comparable in terms of parity, grade of tumor, depth of invasion, histology, surgical treatment lymph node status, postoperative radiation, and concurrent diseases. The outcome events included the number of recurrences and deaths from disease. **Results:** The hormone users were followed for a mean interval of 83 months (95% confidence interval [CI] 71.0, 91.4) and the nonhormone users were followed for a comparable mean interval of 69 months (CI 59.1, 78.7). There were two recurrences (1%) among the 75 estrogen users compared with 11 (14%) recurrences in the 75 nonhormone users. Hormone users had a statistically significant longer disease-free interval than nonestrogen users (P=.006). **Conclusion:** Estrogen replacement therapy with or without progestins does not appear to increase the rate of recurrence and death among endometrial cancer survivors.

Comments: An estimated 36,100 cases of endometrial cancer were diagnosed in the year 2000, making it the fourth most common malignancy in American women and the most common gynecologic malignancy. The overall cure rate is greater than 70%. Due to the high incidence and survival rates associated with endometrial cancer, thousands of women living as survivors may experience the negative long-term sequelae of estrogen deprivation for many years. Estrogen replacement therapy not only improves quality of life by relieving vasomotor symptoms, insomnia, and urogenital atrophy, but it may also provide protection from cardiovascular disease, osteoporosis, colon cancer, and Alzheimer's disease.

The safety of estrogen replacement therapy in women with a diagnosis of endometrial cancer has long been controversial because endometrial cancer is known to be an "estrogen dependent" tumor. Risk factors for developing endometrial cancer include unopposed exogenous estrogen as well as obesity with increased levels of endogenous estrogen production. This information has always lead to fear of the "theoretical" risk of increasing endometrial cancer recurrence after initial treatment by supplying exogenous estrogens.

This study joins three previous retrospective studies that fail to document an increased incidence of recurrent disease among patients exposed to exogenous estrogens. Results of these studies have given clinicians that treat patients with gynecologic cancers the support to offer these women the *option* of receiving estrogen replacement therapy. Patients should be aware of the lack of a prospective, randomized study, and the potential risks involved when making the decision to initiate estrogen therapy. The Gynecologic Oncology Group is currently conducting a prospective, randomized study to provide greater support in answering this question for our patients.

Cervical Cancer Screening: Pap Smear and HPV Testing

Solomon D, Schiffman M, Tarone R; ALTS Study group. Comparison of three management strategies for patients with atypical squamous cells of undetermined significance: baseline results from a randomized trial. J Natl Cancer Inst 2001;93:293-299.

Background: More than 2 million U.S. women receive an equivocal cervical cytologic diagnosis (atypical squamous cells of undetermined significance [ASCUS]) each year. Effective colposcopy triage strategies are needed to identify the minority of women who have clinically significant disease while avoiding excessive follow-up evaluation for others. **Methods**: The ASCUS/LGSIL (i.e., low-grade squamous intraepithelial lesion) Triage Study (ALTS) is a multicenter, randomized trial comparing the sensitivity and specificity of the following three management strategies to detect cervical intraepithelial neoplasia grade 3 (CIN3): 1) immediate colposcopy (considered to be the reference standard), 2) triage to colposcopy based on human papillomavirus (HPV) results from Hybrid Capture 2™ (HC 2) and thin-layer cytology results, or 3) triage based on cytology results alone. This article summarizes the cross-sectional enrollment results for 3488 women with a referral diagnosis of ASCUS. All statistical tests are two-sided. **Results**: Among participants with ASCUS, the underlying prevalence of histologically confirmed CIN3 was 5.1%. Sensitivity to detect CIN3 or above by testing for cancer-associated HPV DNA was 96.3% (95% confidence interval [CI] = 91.6% to 98.8%), with 56.1% of women referred to colposcopy. Sensitivity of a single repeat cytology specimen with a triage threshold of HGSIL or above was 44.1% (95% CI = 35.6% to 52.9%), with 6.9% referred. Sensitivity of a lower cytology triage threshold of ASCUS or above was 85.3% (95% CI = 78.2% to 90.8%), with 58.6% referred. **Conclusions**: HC 2 testing for cancer-associated HPV DNA is a viable option in the management of women with ASCUS. It has greater sensitivity to detect CIN3 or above and specificity comparable to a single additional cytologic test indicating ASCUS or above.

Comments: Of the estimated 50 million Pap smears performed each year in the United States, more than 5% are reported as abnormal. While the majority of equivocal cervical cytology diagnoses (atypical squamous cells of undetermined significance [ASCUS]) reflect a benign process, 5%-10% have been shown to be associated with high-grade squamous intraepithelial lesions (HGSILs). The evaluation of HGSILs has been established as colposcopy with directed biopsies for pathologic examination to confirm diagnosis prior to treatment.

A primary goal of Pap screening and follow-up is to identify and treat high-grade precursor lesions, thus preventing cervical cancer. Therefore, given the relatively large proportion of ASCUS Pap smears associated with HGSILs, effective follow-up of ASCUS Pap reports is essential. Due to their frequency, routine colposcopic evaluation of all ASCUS reports, although providing the greatest patient protection, becomes impractical. Human papilloma virus (HPV) DNA testing for cancer-associated HPV types is a sensitive triage method for detection of HGSILs in the context of an ASCUS cytologic diagnosis. Besides providing a level of certainty to ASCUS results, HPV testing may also decrease Pap examinations, reduce patient anxiety, and minimize loss of high-risk cases during follow-up.

The most streamlined approach to this evaluation makes use of liquid-based Pap tests, which provides a single specimen for both cytology and HPV testing with fewer cases of ASCUS than conventional tests. Liquid-based Pap testing has also been shown to provide increased sensitivity for cervical cytologic abnormalities. Stored specimens from women with corresponding ASCUS cytology results can then be tested for HPV.

Can We Screen for Ovarian Cancer?

Jacobs IJ, Skates SJ, MacDonald N, et al. Screening for ovarian cancer: a pilot randomised controlled trial. Lancet 1999; 353:1207-1210.

Background: The value of screening for ovarian cancer is uncertain. We did a pilot randomised trial to assess multimodal screening with sequential CA 125 antigen and ultrasonography.

Methods: Postmenopausal women aged 45 years or older were randomised to a control group (n=10,977) or a screened group (n=10,958). Women randomised to screening were offered three annual screens that involved measurement of serum CA 125, pelvic ultrasonography if CA 125 was 30 U/mL or more, and referral for gynaecological opinion if ovarian volume was 8.8mL or more on ultrasonography. All women were followed up to see whether they developed invasive epithelial cancers of the ovary or fallopian tube (index cancers). **Findings:** Of 468 women in the screened group with a raised CA 125, 29 were referred for a gynaecological opinion; screening detected an index cancer in six and 23 had false-positive screening results. The positive predictive value was 20.7%. During 7-year follow-up, ten further women with index cancers were identified in the screened group and 20 in the control group. Median survival of women with index cancers in the screened group was 72.9 months and in the control group was 41.8 months (p=0.0112). The number of deaths from an index cancer did not differ significantly between the control and screened groups (18 of 10,977 vs nine of 10,958, relative risk 2.0 [95% CI 0.78-5.13]). **Interpretation:** These results show that a multimodal approach to ovarian cancer screening in a randomised trial is feasible and justify a larger randomised trial to see whether screening affects mortality.

Comments: When a screening test is being considered for use, the disease being screened for should meet the following criteria:

1) The prevalence of disease in the general population should be relatively high
2) The disease should cause substantial morbidity and mortality
3) Earlier diagnosis of the disease should result in an improved outcome
4) There should be an effective screening test for detection of the disease.

More than 25000 women in the United States are diagnosed with ovarian cancer annually, with an associated 14500 deaths. The incidence and mortality appear to be increasing. Although the lifetime risk of developing ovarian cancer in the general population is approximately 1.4%, in certain populations and with hereditary links the risk can increase to up to 65%. Ovarian cancer undoubtedly causes substantial morbidity and mortality with an overall 5-year survival averaging approximately 50%. Early stage diagnosis significantly increases survival from 5% to 40% for women with stage III or IV disease vs. 80% to 90% 5-year survival for stage I or II ovarian cancer. Nevertheless, due to the overall low prevalence of the disease and lack of a highly effective screening test, screening efforts for the detection of ovarian cancer in the general population have been disappointing.

Screening for ovarian cancer cannot currently be recommended for the general population because disease prevalence is too low for the available screening methods to produce acceptable specificity and positive predictive value. Based on personal and family history, women at increased risk should be offered genetic counseling and testing, as well as screening for ovarian cancer when appropriate. Physicians offering or performing ovarian cancer screening should be prepared to address other issues pertinent to high-risk populations, such as genetic counseling and testing, hormone replacement therapy, and prophylactic risk-reducing surgery.

Dr. Bazzett is a practicing gynecologic oncologist at Ochsner.

Depressed Mothers

Heneghan AM, Silver EJ, Bauman LJ, et al. Do pediatricians recognize mothers with depressive symptoms? Pediatrics 2000; 106:1367-1373.

Objective: To determine whether pediatric health care providers recognize maternal depressive symptoms and to explore whether maternal, provider, and visit characteristics affect pediatric providers' ability to recognize inner-city mothers with depressive symptoms. **Design**: A cross-sectional study was conducted at a hospital-based, inner-city, general pediatric clinic. Two groups of participants completed questionnaires, each unaware of the other's responses: 1) mothers who brought their children ages 6 months to 3 years for health care maintenance or a minor acute illness and 2) pediatric health care providers (attending pediatricians, pediatric trainees, and nurse practitioners). The mothers' questionnaire consisted of sociodemographic items and a self-administered assessment of depressive symptoms using the Psychiatric Symptom Index (PSI). Pediatric providers assessed child, maternal, and family functioning and documented maternal depressive symptoms. Criteria for positive identification of a mother by the pediatric health care provider were met if the provider reported one or more maternal symptoms (from a 10-item list of depressive symptoms), a rating of 4 or less on a scale of functioning, a yes response to the question of whether the mother was acting depressed, or a response that the mother was somewhat to very likely to receive a diagnosis of depression. **Results**: Of 338 mothers who completed the questionnaire, 214 (63%) were assessed by 1 of 60 pediatric providers. Seventy-seven percent of surveys were completed by the child's designated pediatric provider. The mean visit length was 23 minutes. Mothers primarily were single, were black or Hispanic, and had a mean age of 26 years (15-45 years). Almost 25% of mothers were living alone with their children. Eighty-six (40%) mothers scored $\geq$20 on the PSI, representing high symptom levels. Of these, 25 were identified by pediatric providers (sensitivity = 29%). A total of 104 of 128 mothers with a PSI score <20 were identified as such by providers (specificity = 81%). Pediatric providers were more likely to identify mothers who were <30 years old, living alone, and on public assistance. Also, mothers who were assessed by the child's own primary provider or by an attending pediatrician were more likely to be identified accurately than were mothers whose children were seen by a pediatric trainee or a nurse practitioner. **Conclusions**: Pediatric health care providers did not recognize most mothers with high levels of self-reported depressive symptoms. Pediatricians may benefit from asking directly about maternal functioning or by using a structured screening tool to identify mothers who are at risk for developing depressive symptoms. In addition, training pediatric providers to identify mothers with depressive symptoms may be beneficial.

Comments: As pediatricians, we sometimes forget that the parents' problems can affect our patients' health. Especially in these days of increased emphasis on productivity requiring us to see more patients daily, we may miss signs of depression in the mother. Common sense tells us that a depressed mother can have a negative influence on her child. In extreme circumstances, especially when mixed with single parenthood, poverty, and other stresses, depression may lead to abuse. But even in moderate cases, depression may still interfere with the health and well-being of children, preventing them from growing in loving, caring relationships. As children's advocates, we should be alert to suspect the sometimes subtle symptoms of depression in the mother, talk with her about it, and refer her to her primary physician for treatment.

Early Anti-Inflammatories Won't Prevent Asthma

Reijonen TM, Kotaniemi-Syrjanen A, Korhonen K, et al. Predictors of asthma three years after hospital admission for wheezing in infancy. Pediatrics 2000; 106:1406-1411.

Objective: To evaluate the influence of early antiinflammatory therapy in the development of asthma 3 years after hospitalization for wheezing in infancy. In addition, the effects of allergic sensitization and respiratory syncytial virus (RSV) infection on the development of asthma were investigated. **Design and**

Setting: A randomized, controlled follow-up study in a university hospital that provides primary hospital care for all pediatric patients in a defined area. **Patients**: Eighty-nine infants under 2 years of age who had been hospitalized for infection associated with wheezing and followed up for 3 years. **Intervention**: Early antiinflammatory therapy was given for 16 weeks; 29 patients received cromolyn sodium and 31 received budesonide. Twenty-nine control patients received no therapy. **Outcome Measures**: Clinical diagnosis of current asthma, defined as having at least 3 episodes of physician-diagnosed wheezing and either a wheezing episode during the preceding year or ongoing antiinflammatory medication for asthma. **Results**: Fourteen (48%) patients in the former cromolyn group, 15 (48%) in the former budesonide group, and 16 (55%) in the control group had current asthma. The significant predictors of asthma were age over 12 months (risk ratio [RR] 4.1; 95% confidence interval [CI] = 1.59-10.35), history of wheezing (RR 6.8; CI = 1.35-34.43), and atopic dermatitis on study entry (RR 3.4; CI = 1.17-9.39). Skin prick test positivity at the age of 16 months significantly predicted asthma (RR 9.5; CI = 2.45-36.72). In addition, all of the 18 (20%) children sensitized with furred pet developed asthma. RSV identification (RR 0.3; CI = 0.08-0.80) and early furred pet contact at home (RR 0.3; CI 0.10-0.79) were associated with the decreased occurrence of asthma. **Conclusions**: Antiinflammatory therapy for 4 months has no influence on the occurrence of asthma 3 years after wheezing in infancy. Early sensitization to indoor allergens, especially to pets, and atopic dermatitis predict subsequent development of asthma. RSV infection in wheezing infants may have a better outcome than other infections.

Comments: We are all aware of the asthma management revolution of the last decade with the focus on first line anti-inflammatory drugs. Might these medications prevent asthma if used in infants who wheeze? Unfortunately, based on this study, the answer is no. Avoiding indoor allergens, especially furred pets, is one of the practical issues to discuss with parents of infant wheezers. The study also showed something unexpected, infants who wheezed due to RSV were less likely to have asthma 3 years later. The authors' search for predictors of asthma was expected: age > 12 months, history of wheezing, and atopic dermatitis and positive skin prick test at 16 months of age.

Fever Phobia

Crocetti M, Moghbeli N, Serwint J. Fever phobia revisited: Have parental misconceptions about fever changed in 20 years? Pediatrics 2001; 107: 1241-1246.

Objectives: Fever is one of the most common reasons that parents seek medical attention for their children. Parental concerns arise in part because of the belief that fever is a disease rather than a symptom or sign of illness. Twenty years ago, Barton Schmitt, MD, found that parents had numerous misconceptions about fever. These unrealistic concerns were termed "fever phobia." More recent concerns for occult bacteremia in febrile children have led to more aggressive laboratory testing and treatment. Our objectives for this study were to explore current parental attitudes toward fever, to compare these attitudes with those described by Schmitt in 1980, and to determine whether recent, more aggressive laboratory testing and presumptive treatment for occult bacteremia is associated with increased parental concern regarding fever. **Methods**: Between June and September 1999, a single research assistant administered a cross-sectional 29-item questionnaire to caregivers whose children were enrolled in 2 urban hospital-based pediatric clinics in Baltimore, Maryland. The questionnaire was administered before either health maintenance or acute care visits at both sites. Portions of the questionnaire were modeled after Schmitt's and elicited information about definition of fever, concerns about fever, and fever management. Additional information included home fever reduction techniques, frequency of temperature monitoring, and parental recall of past laboratory workup and treatment that these children had received during health care visits for fever. **Results**: A total of 340 caregivers were interviewed. Fifty-six percent of caregivers were very worried about the potential harm of fever in their children, 44% considered a temperature of 38.9 degrees C (102 degrees F) to be a "high" fever, and 7% thought that a temperature could rise to ≥ 43.4 degrees C (≥ 110 degrees F) if left untreated. Ninety-one percent of caregivers believed that a fever could cause harmful effects; 21% listed brain damage, and 14% listed death. Strikingly, 52% of caregivers said that they would check their child's temperature ≤ 1 hour when their child had a

fever, 25% gave antipyretics for temperatures ≤ 37.8 degrees C (≤ 100 degrees F), and 85% would awaken their child to give antipyretics. Fourteen percent of caregivers gave acetaminophen, and 44% gave ibuprofen at too frequent dosing intervals. Of the 73% of caregivers who said that they sponged their child to treat a fever, 24% sponged at temperatures ≤ 37.8 degrees C (≤ 100 degrees F); 18% used alcohol. Forty-six percent of caregivers listed doctors as their primary resource for information about fever. Caregivers who stated that they were very worried about fever were more likely in the past to have had a child who was evaluated for a fever, to have had blood work performed on their child during a febrile illness, and to have perceived their doctors to be very worried about fever. Compared with 20 years ago, more caregivers listed seizure as a potential harm of fever, woke their children and checked temperatures more often during febrile illnesses, and gave antipyretics or initiated sponging more frequently for possible normal temperatures. **Conclusions**: Fever phobia persists. Pediatric health care providers have a unique opportunity to make an impact on parental understanding of fever and its role in illness. Future studies are needed to evaluate educational interventions and to identify the types of medical care practices that foster fever phobia.

Comments: Most parents are scared about their children's fevers and possible bad outcomes. This fever phobia is just as bad, or worse, than 20 years ago, and this study showed that 46% of caregivers listed their doctors as the primary sources of information about fever. I cannot agree more with the authors in the fact that pediatric health care providers have unique opportunities to impact parental understanding of fever. When evaluating a child with fever, we should take the opportunity to teach parents that fever is a physiologic response of the body. It stimulates the body's inflammatory responses, therefore killing viruses and bacteria. In most cases, fever is not dangerous. Fever is not a disease but rather a symptom, and parents should be taught when to worry. If the child has only 101^{o} F but looks sick and lethargic, he should be evaluated soon. On the opposite side, if the child has a temperature of 104^{o} or 105^{o}, but he is playing and running around, then there is less concern. Fever in an infant less than 2 months of age should be evaluated. There are protocols to follow for the appropriate work-ups. The study pointed out a big concern for pediatric health care providers. Fourteen percent (14%) of the parents gave acetaminophen every 3 hours or less, 44% gave the ibuprofen every 5 hours or less. Such practices place the children at risk for toxicity unnecessarily. When educating the parents, we can direct them to sound advice provided by several publications on patient education. We can also help parents by training our residents wisely in the correct management of fever rather than fever phobia.

Inhaled Anti-Inflammatories and ED Visits

Adams RJ, Fuhlbrigge A, Finkelstein JA, et al. Impact of inhaled antiinflammatory therapy on hospitalization and emergency department visits for children with asthma. Pediatrics 2001; 107: 706-711.

Objective: Although the efficacy of inhaled antiinflammatory therapy in improving symptoms and lung function in childhood asthma has been shown in clinical trials, the effectiveness of these medications in real-world practice settings in reducing acute health care use has not been well-evaluated. This study examined the effect of inhaled antiinflammatory therapy on hospitalizations and emergency department (ED) visits by children for asthma. **Design**: Defined population cohort study over 1 year. **Setting**: Three managed care organizations (MCOs) in Seattle, Boston, and Chicago participating in the Pediatric Asthma Care-Patient Outcome Research and Treatment II trial. **Participants**: All 11 195 children, between 3 to 15 years old, with a diagnosis of asthma who were enrolled in the 3 MCOs between July 1996 and June 1997. **Outcome Measures**: We identified children with 1 or more asthma diagnoses using automated encounter data. Medication dispensings were identified from automated pharmacy data. Multivariate logistic regression analysis was used to calculate effects of inhaled antiinflammatory therapy on the adjusted relative risk (RR) for hospitalization and ED visits for asthma. **Results**: Over 12 months, 217 (1.9%) of children had an asthma hospitalization,

and 757 (6.8%) had an ED visit. After adjustment for age, gender, MCO, and reliever dispensing, compared with children who did not receive controllers, the adjusted RRs for an ED visit were: children with any (≥ 1) dispensing of cromolyn, 0.4 (95% confidence interval [CI]: 0.3, 0.5); any inhaled corticosteroid (ICS), 0.5 (95% CI: 0.4, 0.6); any cromolyn or ICS combined (any controller), 0.4 (95% CI: 0.3, 0.5). For hospitalization, the adjusted RR for cromolyn was 0.6 (95% CI: 0.4, 0.9), for ICS 0.4 (95% CI: 0.3, 0.7), and for any controller 0.4 (95% CI: 0.3, 0.6). A significant protective effect for both events was seen among children with 1 to 5 and with >5 antiinflammatory dispensings. When the analysis was stratified by frequency of reliever dispensing, there was a significant protective effect for controllers on ED visits for children with 1 to 5 and with >5 reliever dispensings and on the risk of hospitalization for children with >5 reliever dispensings. **Conclusions**: Inhaled antiinflammatory therapy is associated with a significant protective effect on the risk for hospitalization and ED visits in children with asthma. Cromolyn and ICSs were associated with similar effects on risks, asthma drug therapy, inhaled antiinflammatory agents, health maintenance organizations, hospitalization, emergency department.

Comments: This large sample study of 11 195 children between 3 and 15 years of age enrolled in three managed care organizations proved what we have already seen in clinical practice: the appropriate management of asthma decreases the number of hospitalizations and emergency department visits. This also reduces the costs of treating the disease. Quality of life is also improved by the use of the anti-inflammatories. It is great to see children who could not play at all before treatment with anti-inflammatories being able to participate in organized sports and other active pastimes. We have the medicines to treat asthma; now we need to continue educating physicians, parents, patients, schoolteachers and all the personnel involved in the care of children in order to impact the disease and stop the frightening rate of increasing mortality.

Dr. Fox in on staff in the Family Medicine Department at the Ochsner Clinic, Lapalco.

Is Perception of Time Spent With the Physician a Determinant of Patient Satisfaction?

Lin CT, Albertson GA, Schilling LM, et al. Is patients' perception of time spent with the physician a determinant of ambulatory patient satisfaction? Arch Intern Med 2001; 161:1437-1442.

Background: Time management in abulatory patient visits is increasingly critical. Do patients who perceive a longer visit with internists report increasing satisfaction? **Methods:** Prospective survey of 1486 consecutively encountered ambulatory visits to 16 primary care physicians (PCPs) in an academic primary care clinic. Patients were queried regarding demographics, health status, perception of time spent before and after ambulatory visits, whether the physician appeared rushed, and visit satisfaction. Physicians were queried regarding time spent, estimated patient satisfaction, and whether they felt rushed. **Results:** In 69% of 1486 consecutive visits, patient previsit expectation of visit duration was 20 minutes or less. Patient and PCP postvisit estimates of time spent significantly exceeded patient previsit time expectation. Patients who estimated that they spent more time than expected with the PCP were significantly more satisfied with the visit. When patient

postvisit estimate of time spent was less than the previous expectation, visit satisfaction was significantly lower independent of time spent. Patient worry about health and lower self-perceived health status were significantly lower when they felt rushed in 10% of encounters. Although PCPs estimated patient satisfaction was significantly lower when they felt rushed, patient satisfaction was identical when PCPs did and did not feel rushed. Patients indicated that PCPs appeared rushed in 3% of encounters, but this perception did not affect patient satisfaction. **Conclusion:** Perceived ambulatory visit duration and meeting or exceeding patient expectation of time needed to be spent with the physician are determinants of patient satisfaction in an ambulatory internal medicine practice.

Comments: Recent surveys document that ambulatory visits to family practitioners and internists have declined in duration over the last 15 years. It is reassuring that the standard 20 minute office visit in this study met the expectations of the majority of patients. The standard patient schedule does not meet the expectations of patients with greater health concerns. This is not surprising. I suspect the most cost-effective method of satisfying this subgroup of worried patients would include the involvement of ancillary health professionals.

Complimentary and Alternative Medicine

Palinkas LA, Kabongo ML. The use of complementary and alternative medicine by primary care patients. A SURF*NET study. J Fam Pract 2000;49: 1121-1130.

Background: Despite the increased use and acceptance of complementary and alternative medicine (CAM) practices and practitioners by patients and health care providers, there is relatively little information available concerning the reasons for use or its effect on patient health status and well-being. **Methods**: We conducted a survey of 542 patients attending 16 family practice clinics that belong to a community-based research network in San Diego, California, to determine patients' reasons for using CAM therapies in conjunction with a visit to a family physician and the impact of these therapies on their health and well-being. **Results**: Approximately 21% of the patients reported using one or more forms of CAM therapy in conjunction with the most important health problem underlying their visit to the physician. The most common forms of therapy were visiting chiropractors (34.5% of CAM users), herbal remedies and supplements (26.7%), and massage therapy (17.2%). Recommendations from friends or coworkers, a desire to avoid the side effects of conventional treatments, or failure of conventional treatments to cure a problem were the most frequently cited reasons for using these therapies. Use of practitioner-based therapies was significantly and independently associated with poor perceived health status, poor emotional functioning, and a musculoskeletal disorder, usually low back pain. Use of self-care-based therapies was associated with high education and poor perceived general health compared with a year ago. Use of traditional folk remedies was associated with Hispanic ethnicity. **Conclusions**: Sociodemographic characteristics and clinical conditions that predict use of CAM therapies by primary care patients in conjunction with a current health problem vary with the type of therapy used.

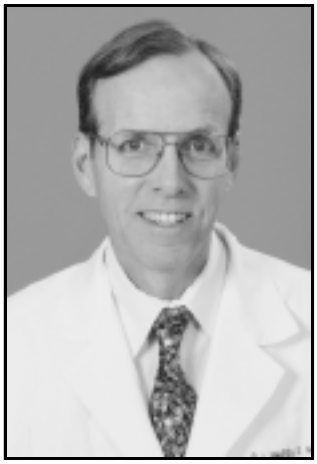
Comments: Two of the three most commonly used alternative therapies (chiropractic and massage therapy) treat musculoskeletal conditions that do not respond well to traditional medical management. It should be no surprise that patients would seek alternative therapies for the recalcitrant problems of neck pain and low back pain. In this survey, self-care-based therapy use indicated patient empowerment more than patient dissatisfaction, and use of old remedies was highly associated with patients' adherence to their cultural heritage. There are strong motivations for use of alternative therapies by patients, and a practitioner should be accepting of these therapies unless they are documented to be harmful.

Clinical Breast and Pelvic Examination Requirements for Hormonal Contraception: Current Practice vs. Evidence

Stewart FH, Harper CC, Ellertson CE, et al. Clinical breast and pelvic examination requirements for hormonal contraception: Current practice vs evidence. JAMA 2001; 285:2232-2239.

Clinical breast and pelvic examinations are commonly accepted practices prior to provision of hormonal contraception. Such examinations, however, may reduce access to highly effective contraceptive methods, and may therefore increase women's overall health risks. These unnecessary requirements also involve ethical considerations and unwittingly reinforce the widely held but incorrect perception that hormonal contraceptive methods are dangerous. This article reviews and summarizes the relevant medical literature and policy statements from major organizations active in the field of contraception. Consensus developed during the last decade supports a change in practice: hormonal contraception can safely be provided based on careful review of medical history and blood pressure measurement. For most women, no further evaluation is necessary. Pelvic and breast examinations and screening for cervical neoplasia and sexually transmitted infection, while important in their own right, do not provide information necessary for identifying women who should avoid hormonal contraceptives or who need further evaluation before making a decision about their use.

Comments: There are clear medical contraindications to the use of hormonal contraception. Usually identified by a medical history and blood pressure measurement, these conditions include hypertension, deep vein thrombosis, current breast cancer, certain liver diseases, etc. Breast and pelvic examinations are important screening examinations in women, but this fact is not related to whether or not women use hormonal contraception. Using initiation of hormonal contraception as a "hook" for these screening examinations has had the unwanted results of discouraging effective contraceptive use in teenagers and reinforcing the incorrect belief that hormonal contraceptive methods are dangerous.



Dr. Marquis is the Associate Chairman of Ochsner's Family Medicine Department for the West Bank and Bayou regions.