copy is not performed. Both modalities are useful for clinicians who understand the relative merits of each in the complex management of peptic ulcer disease.

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Management of Parkinson Disease

To the Editor: With regard to the article by Manyam (Manyam BV. Practical guidelines for management of Parkinson disease. J Am Board Fam Pract 1997;10:412-2), I wish to comment on two recommendations for drug treatment of Parkinson disease. As noted in the article, compared with younger patients, elderly patients have a much higher sensitivity to anticholinergic side effects of medications, which can often precipitate confusion and occasionally frank delirium. As a result, many clinicians prefer to prescribe selective serotonin reuptake inhibitors rather than amitriptyline for depression. In addition, amitriptyline can cause orthostatic hypotension and cardiac conduction disturbances (atrioventricular node block), which can be more problematic in older patients.

For the treatment of agitation associated with dementia in patients with Parkinson disease, some geriatric psychiatrists currently recommend olanzapine as the antipsychotic medication of choice because it does not cause extrapyramidal side effects. This drug is preferred to clozapine because there is no need to monitor for agranulocytosis.

Management of Parkinson disease, especially in a person with concomitant illnesses, can be challenging for the physician. I am pleased to see Dr. Manyam's comprehensive overview as a reference for clinicians.

Linda Mandanas, MD
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The above letter was referred to the author of the article in question, who offers the following reply.

Dr. Mandanas is right in her observation that elderly patients are more sensitive to anticholinergic side effects when antidepressants are administered in the usual adult doses. In spite of my awareness of the above fact, I still prefer amitriptyline as my initial drug for treating depression in patients with Parkinson disease provided there are no contraindications (dementia, bradycardia, benign prostatic hypertrophy). I start with 25 mg at night and very gradually increase the dose. Most patients have good results with 50 or 75 mg.

Amitriptyline has duel benefits in patients with Parkinson disease—an antidepressive effect and an antitremor effect as a result of its anticholinergic component. If the patient does not tolerate amitriptyline, then I prescribe a different antidepressant drug. In the subsection on dementia in my article (p 420), I suggested that if dementia or hallucination is already present, anticholinergic drugs in all forms should be avoided. Because orthostatic hypotension can be caused by the primary disease itself or the medications, I routinely obtain pulse rate and supine and upright blood pressures in all Parkinson disease patients. My article was written as a general guide, and the suggestions offered should be modified based on individual patient's condition.

I agree with Dr. Mandanas' suggestion regarding the use of olanzapine, which does not require uncomfortable monitoring for agranulocytosis or the related paperwork.

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Health Problems of Refugees

To the Editor: Dr. Ackerman[1] uses a creative approach in determining important medical and cultural issues of refugees. She acknowledges that most data are from studies conducted in the country of origin. We agree there is a dearth of data on health care of refugees once they arrive in the United States. Furthermore, there is little information on the costs of medical care provided to refugees.

Dr. Ackerman cites the experience of some Somali and Ethiopian children who arrived in Buffalo, NY, with inadequate immunizations, anemia, intestinal parasites, and dental caries.[1,2] We were involved with the Refugee Health Project in Buffalo from 1987 to 1994. More than 1500 refugees were triaged through our Refugee Health Center during a 1-year period (1991-92). Our estimated expenses for that year were $202,800 (in 1992 dollars). Costs included hospital care, nursing salaries for the health project, vaccines and Mantoux testing, medical supplies, and transportation to medical facilities. Of 306 refugees examined and tested that year, 27 percent had positive tuberculosis (PPD) test results. Many had intestinal parasites. Nine refugees were hospitalized during the 1991-92 period, 2 were for psychiatric reasons, 4 women were in labor, and 3 children had pyelonephritis, vasculitis, and typhoid, respectively.

Other health problems might have been a consequence of hardships the refugees and their families had endured in refugee camps en route to the United States. We documented malnutrition, overwhelming fatigue, scabies, and dysentery. Depression, anxiety, and even psychosis were not unusual. Few pregnant women reported prenatal care. Persons with chronic conditions arrived without needed medications. Some refugees had been tortured or mutilated; 3 women reported be-

ing raped by agents who arranged their passage.

We wholeheartedly agree with Dr. Ackerman that ongoing clinical trials are needed. In addition, we believe it is critically important to determine costs of care and mechanisms of reimbursement. The costs of not caring for refugees could outweigh resources spent on detecting illness and preventing complications.

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The Doctor, the Patient, and the Home

To the Editor: Ian R. McWhinney[1] points out the value of caring for patients in their homes, both to them and to their physicians, who thereby get to know their patients better. Dr. McWhinney's article deals mainly with the elderly and dying. There is another time in people's lives when being at home can be an important emotional and spiritual experience: the time of giving birth. Recent reports from the United States, England, the Netherlands, and Switzerland[2-5] again show that home birth can be a safe option for well-selected patients. Most home births in the United States are attended by midwives, but most physicians who attend home birth are family physicians. The climate of fear that surrounds home birth, at least among physicians, has never been supported by evidence of increased risk. Will the time come when this subject can be looked at dispassionately? Our patients will be better served if it does.

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Training Residents to Care for Handicapped Patients

To the Editor: I would like to commend Goodenough and Hole-Goodenough for their article regarding residency training in the care of mentally handicapped patients.[1] The authors highlight the importance of training our future family physicians on caring for persons with mental handicaps. I would also like to emphasize the importance of family physician involvement with disabled patients and their families. This care can be of special benefit to more than 2.9 million children in the United States with disabilities.[2]

Family physicians are in an ideal position to care for these children and their families, whose population is increasing as a result of increased survivability. These families need primary care providers who are able to address the needs of the family as a whole and who can provide continuity as these children move into adulthood. The families with exceptional children often are not looking for an expert on their child's disability; rather, they want someone who knows their family and who knows what resources are available for their child.[3]

As the authors eloquently stated, many family physicians are not provided with the training needed to understand how to use such resources as respite care, parent support groups, early intervention services, and school special education services. Our residency has a unique family practice-based Developmental Disabilities Continuity Clinic, which involves residents in researching resources, interacting with our local special education system, and providing on-going support to these families. Although some of this training can be supplemented by community service in areas such as Special Olympics and at specialized camps for children with disabilities; the importance of further developing our family practice faculty in this area cannot be overemphasized.

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