We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in come cases. The problem is compounded in a bimonthly journal where continuity of comment and redress are difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Value of Review of Systems

To the Editor: I agree that it is important to study history taking, including the review of systems. In fact, while I was in medical school, 2 of my fellow students and I completed a research project on the review of systems. In contrast to Verdon and Siemens,[1] we looked at the yield of general questions (short version with 39 questions) versus specific questions (an oral long version and the written Cornell Medical Index, which was nearly 200 questions). Thus, we compared, "Have you had any trouble with your chest?" with a series of specific questions such as, "Have you had chest pain or pressure?" We found that the general questionnaire picked up many of the important items with a shorter completion time with some exceptions. For example, patients did not apparently perceive rectal bleeding as important and would not mention it in response to a general question.

Although we never submitted our paper for publication (but I got a "pass" for that research elective!), my experience with the research and my use of the review of systems in practice led me to some reflections on Verdon and Siemens' paper. First, their results highlight one of the shortcomings of review of system questionnaires: malpractice liability because a symptom is noted in the record but unaddressed. For example, there was no documentation for follow-up of a substantial number of cases, including something as potentially serious as rectal bleeding. If we are going to ask, we need to be ready to address the answer. Second, their patient population is young and their review of systems questionnaire is shorter than any I have ever used, which might affect its usefulness and generalizability.

Thus, I would take issue with concluding "there would be few life-threatening consequences from eliminating the ROS section from a self-administered questionnaire" (page 27). I suspect more work is needed with different questions in different populations to come to this conclusion. It could be that there are a few well-chosen questions, such as regarding rectal bleeding in an older population, that would have high yield. For example, a recent report[2] found that serious disease (including 13 cancers) was present in 24 percent of 297 middle-aged men who responded positively to the rectal bleeding question in a short review of systems questionnaire. We need to continue our search for the right, high-yield questions.

Marjorie A. Bowman, MD, MPA
Philadelphia, Pa

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1. Verdon ME, Siemens K. Yield of review of systems in a self-administered questionnaire. J Am Board Fam Pract 1997; 10:20-7.
2. Helfand M, Marton KI, Zimmer-Gembeck MJ, Sox HC Jr. History of visible rectal bleeding in a primary care population: Initial assessment and 10-year follow-up. JAMA 1997; 277:44-8.

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

To the Editor: Dr. Bowman's comments raise an important issue. The yield of any review of systems might depend on the population studied. One approach to the review of systems might be to tailor the questions based on age and other demographics. More published research is needed in a variety of settings to further our information on this subject. The results would help determine whether there is an ideal set of questions and with whom and when it should be used. Screening is a science, and we are just beginning the study of this commonly used tool.

Mary E. Verdon, MD
Lambertville, NJ

Pneumococcal Vaccination

To the Editor: Elangovan et al investigated an important issue in "Improving Pneumococcal Vaccination Rates in an Elderly Population by Patient Education in an Outpatient Clinic."[1] The article title is a bit misleading, however, in that there was more than just patient education being studied.

It is unclear from the methodology whether the physicians were in any way blinded: that a study of vaccination is being performed will obviously enhance compliance with such, regardless of the intervention (Hawthorne effect).[2]

Another aspect of the intervention involved the research nurse flagging the charts: there is no control arm of the study to separate the impact of chart flagging from patient education. This oversight is important in that other investigators have found no effect of patient education on compliance,[3] but checklists have been shown to improve vaccination rates significantly.[4,5] Consequently, the reader cannot tell whether the results of the study might be due entirely to the flagging of the charts.

This criticism should not detract from the excellent compliance rates achieved in the study population, nor

from the authors' efforts to expand the literature that investigates enhanced compliance with preventive health measures.

David L. Smith, MD
Voorhees, NJ

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3. Herman CJ, Speroff T, Cebul RD. Improving compliance with immunization in the older adult: results of a randomized cohort study. J Am Geriatr Soc 1994;42:1154-9.
4. McDonald CJ, Hui S, Smith DM, Tierney WM, Cohen SJ, Weinberger M, et al. Reminders to physicians from an introspective computer medical record. A two-year randomized trial. Ann Intern Med 1984;100:130-8.
5. Cohen DI, Littenberg B, Wetzel C, Neuhauser D. Improving physician compliance with preventive medicine guidelines. Med Care 1982;20:1040-5.

The above letter was referred to the authors of the article in question, who offer the following reply.

To the Editor: We appreciate Dr. Smith's interest in our study on improving vaccination rates in the elderly. This study investigated the impact of a patient education intervention on the pneumococcal vaccination rate in elders. It was, therefore, a study of patient behavior rather than physician behavior. All elderly patients who had not received pneumococcal vaccination were provided patient education in the waiting room by a research nurse before seeing their physician. Each patient was offered the opportunity to be vaccinated that day. All physicians had previously agreed to provide vaccination to their patients who consented to receive it that day, unless there were contraindications. The flagging of the patient chart was simply a way to alert the physician to the patient's consent for vaccination.

Sudah Elangovan, MD, PhD
Ken J. Kallail, PhD
Wichita, Kan

Breath Test, Endoscopy, and Peptic Ulcer Disease

To the Editor: The recently published letter by Dr. Zoorob in the *Journal* was appreciated (Zoorob RJ. NIH consensus on *Helicobacter pylori* in peptic ulcer disease. J Am Board Fam Pract 1996;9:392). Dr. Zoorob's emphasis on the presenting complaint of dyspepsia as opposed to the pathophysiologic disease of ulcer is well taken.

On the other hand, I am not very optimistic about the breath test as a means of diagnosis or guiding therapy for *H pylori* eradication. Certainly more studies should be done, but at this time I think the continuing high occurrence in asymptomatic patients makes the actual detection of *H pylori* less than definitive.

During the 10 years that I have been performing esophagogastroduodenoscopy (EGD) in family practice, I think the most powerful background I bring to each patient encounter is my psychosocial foundation in the medical specialty of family practice. At least 35 percent of the patients within our teaching practice come to each endoscopy with substantial psychosocial co-morbidity. Of course they have dyspepsia or other gastrointestinal symptoms that merit investigation; however, these symptoms do not lead to pure gastrointestinal diagnoses. The most powerful management usually combines all of the various conditions affecting the patient. I therefore totally agree with the need for family physicians to be involved in the process of formulating clinical guidelines. It is my hope that family physicians will continue to produce the clinical research leading to the optimal management of common conditions such as the peptic disease syndrome. *H pylori* eradication is one dimension within this larger problem.

Pending further definitive research, primary care EGD is probably going to be the best approach for patients who fail empirical therapy with H_2 receptor antagonists. Widespread empirical prescriptions of antibiotics in the hope of eradicating *H pylori* run the risk of producing drug-resistant strains.

A shotgun approach regarding *H pylori* eradication in all patients with positive breath tests is unlikely to be helpful for the majority of patients with garden variety dyspepsia in family practice.

Wm. MacMillan Rodney, MD
Memphis, Tenn

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

To the Editor: Dr. Rodney brings up several important points regarding the presentation of peptic ulcer disease and dyspepsia in primary care settings. I agree that psychosocial issues and nonulcer dyspepsia, which are usually unrecognized by subspecialists, are the predominant factors in primary care. I could not emphasize more that symptomatic treatment for dyspepsia should always precede investigation or endoscopy. Although I am in an academic center, I still find it hard as a family physician to accept that primary care endoscopy be performed on all nonresponders to symptomatic treatment.

I admire Dr. Rodney's procedural experience and efforts to train family physicians in endoscopy. Nevertheless, it is not nationally feasible at this time to recommend EGD by family physicians for all nonresponders to H_2-blockers. Moreover, although antibiotic resistance is a legitimate concern, empirical treatment is by far most effective in patients with high pretest probability for *Helicobacter pylori*.[1] Similarly, cost-benefit analysis has echoed the same recommendation,