We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some 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.

Colposcopy and Referral

To the Editor: Regarding the article by Prislin et al (Prislin MD, Dinh T, Giglio M. On-site colposcopy services in a family practice residency clinic: impact on physician test-ordering behavior, patient compliance, and practice revenue generation. J Am Board Fam Pract 1997;10:259-64), I wish to comment on a factor that affects the economic calculations for offering services such as colposcopy in a private practice. When we refer a woman to a gynecologist for a colposcopy, she is usually lost to us for any further gynecologic care and for eventual obstetric care. In our specialty-oriented suburban community, this often means that her babies will be then cared for by pediatricians. These women and their families are often relatively young and healthy and help balance the sicker and needier parts of the patient load. The direct income gained as a result of doing colposcopy in the office is far less important to us than the privilege and responsibility of providing ongoing care, as well as the income generated by that care over the long haul.

A residency practice copes with a changing physician population, and possibly with patients whose insurance (or lack of it) makes them less attractive to private consultants. It might be more difficult in that setting to calculate the economic value of an ongoing physician-patient relationship.

Rebecca C. Preston, MD
LaGrange Park, Ill

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

To the Editor: Dr. Preston raises an important issue. Will family physicians lose patients if they are unable to provide colposcopic services? Given the medical indigency of our patient populations, their return to our practice following referral for colposcopy was, not surprisingly, nearly universal.

We believe that our study provides substance to the dilemma raised by Nuovo and Melnikow.[1] Improved understanding of the epidemiology of cervical cytopathologic abnormalities is leading to the emergence of new clinical guidelines that will result in far fewer patients requiring colposcopy than previously thought. Although colposcopy is not currently among the most frequent procedures performed by practicing family physicians, it is among the most frequent procedures for which family practice residents are now receiving training.[2] Experience with other areas of procedural training during family practice residency suggests that a clear relation between provision of training and subsequent increases of utilization in practice exists.[3]

The potential overutilization of colposcopy has enormous cost implications. Perhaps, as Pfenninger suggests, colposcopy could come to be considered a routine element of gynecologic care, and thus not engender an additional procedural fee.[4] Yet colposcopy inevitably leads to cervical biopsy and in some cases to further therapeutic interventions that incur both additional expense and potential morbidity.

We do not advocate that family physicians cease to provide colposcopic services. We do question whether all family physicians should perform colposcopy. There is absolutely nothing preventing practicing family physicians from fostering the development of collaborative intradisciplinary referral relationships. In such an environment one might have greater assurance of maintaining ongoing patient care continuity.

Michael D. Prislin, MD
Truc Dinh, MD
Mark Giglio, MD
Orange, Calif

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3. Saad JA, Pirie P, Sprafka JM. Relationship between flexible sigmoidoscopy training during residency and subsequent sigmoidoscopy performance in practice. Fam Med 1994; 26;250-3.
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Withdrawal of Antihypertensive Medications

To the Editor: In an editorial comment on our article "Withdrawal of Antihypertensive Medications,"[1] Grimm[2] misreads both the content and intent of our paper. We do not advocate withdrawing antihypertensive medications from patients who need them or, even at this time, from patients who might not. We present studies that indicate antihypertensive medications have been withdrawn successfully in a substantial number of patients and that a great many New York family physi-