Correspondence

We 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 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.

Self-Collection of Antepartum Anogenital Group B Streptococcus Cultures

To the Editor: In reference to the article by Drs. Torok and Dunn concerning self-collection of antepartum anogenital cultures (Torok PG, Dunn JR. Self-collection of antepartum anogenital group B streptococcus cultures. J Am Board Fam Pract 2000;13:107–10), I would like to address two issues. First, I am hard-pressed to understand where the cost savings would actually occur. The culture handling is unchanged from collection, and the likelihood of patient mishandling is high enough that I would not be comfortable with the proposed actions. If self-collection is supposed to limit the amount of physician interaction time with the patient, the time has got to be absolutely minimal (less than 1 minute if the patient is prepared by the nurse staff before the physician visit). A 36-week postpartum examination is typically different from "routine" antepartum visits, and our patients are told early on that this examination will typically involve blood work and cultures.

The second issue is that our practice has a high rate of asymptomatic chlamydial infections. So high, in fact, that we routinely do vaginal swabs for *Neisseria gonorrhea* and *Chlamydia trachomatis* at the patient's initial visit and again at 36 weeks. Given the current concerns about *C trachomatis* and risk of premature rupture of membranes and preterm labor, we have found it a reasonable approach to our population of patients. The controversy regarding screening all patients for sexually transmitted disease notwithstanding, I am certain that we have gained valuable information with this surveillance.

The cost savings and patient comfort issues we hear about are a hallmark of today's medicine. I am uncomfortable leaving this portion of the examination to the patient and limiting the interaction with the physician. The possibility of missing a mucopurulent discharge and potentially harmful infection because the "patient did the swab" will be poorly tolerated in the face of a sick neonate and a hungry attorney.

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Uterine Inversion

To the Editor: The article on uterine inversion by Hostetler and Bosworth in the March-April 2000 issue of *JABFP* (Hostetler DR, Bosworth MF. Uterine inversion: a life-threatening obstetric emergency. J Am Board Fam Pract 2000;13:120–3) brought to mind my own experience of this situation as a second-year resident. As outlined in the article, we proceeded through a number of steps before using general anesthesia to relax the uterus. The attending physician had removed the placenta, and my memory is of tension and a great deal of blood.

One useful part of the treatment was not addressed in the article. Even after our patient was under general anesthesia, the attending physician (who was an obstetrician) could not easily manipulate the uterus back into position. At the point of considering emergency surgery, the anesthesiologist stated he had been in this situation a couple of times, "years ago when I was in general practice." He was able to reposition the uterus successfully, and afterward the attending physician asked what he had done. He described the following, which might be useful for anyone who is confronted with this harrowing situation.

Imagine a thick rubber balloon that you are attempting to turn inside out. Pressing at the bottom creates a dimpling effect, resulting in a lot of tissue to force through the narrow neck. Instead, the anesthesiologist began by pushing close to the narrow opening, at the "neck of the balloon," so to speak. He slowly pushed the narrowest part of the uterus through the cervix, which further dilated the opening so he could feed the remaining body of the uterus through the cervix.

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Ethics of Screening

To the Editor: Thank you for the wise decision to publish the article on the ethics of screening by Dr. Ewart in the May-June issue of the *JABFP* (Ewart RM. *Primum non nocere* and the quality of evidence: rethinking the ethics of screening. J Am Board Fam Pract 2000;13:188–96). Dr. Ewart's salient and challenging assertions regarding beneficence, nonmaleficence, and the paucity of reliable screening data direct us to bridge the gaps between standards of practice and standards of reason. Gaps, which left neglected, threaten to harm our patients and diminish our profession.

Efforts to reassess the presumed benefits of screening programs, to weigh the inherent harms of screening examinations, and to approach skeptically the recommendations of influential organizations should be welcomed and joined. Like our patients, we need to improve our understanding of the individual screening tests we recommend. Perhaps one place to begin is to compare