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

our personal use of screening examinations with our professional recommendations to our patients.

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Trimethoprim-Sulfamethoxazole-Induced Hypoglycemia

To the Editor: As a geriatrician I would like to comment on a statement in the brief report by Mathews et al.[1] Specifically, the authors state: "Creatine clearance can be estimated easily and *accurately* [emphasis added] using this formula: (140−age)(weight in kg)(0.85 for women)/72(serum creatinine in mg/dL)."

The Cockroft-Gault equation (above) is probably the most frequently used equation to estimate creatinine clearance and is certainly one of the simpler and easier equations to apply in practice.

The accuracy of the Cockroft-Gault equation in predicting creatinine clearance in the elderly, however, is still being debated, not only for the extremes of age and when multiple comorbidities are present, but also for the healthy elderly. In the elderly, when values obtained from the Cockroft-Gault equation are compared with actual measured creatinine clearance rates, the creatinine clearance is often meaningfully different from what the Cockroft-Gault equation would predict. The Cockroft-Gault equation should therefore be considered for what it is—a quick clinical guesstimate. In the studies, when lines are plotted using statistical methods, nice equations are generated for clinical estimation of creatinine clearance in the population. When one looks at the actual plots and scatter, however, there is considerable individual variation. For example, in the Fliser et al study,[2] elderly patients with measured 24-hour creatinine clearance rates of about 40 mL/min had predictions by the Cockroft-Gault equation ranging from about 40–120 mL/min. Conversely, elderly patients whose Cockroft-Gault equation predicted a creatinine clearance of 40 mL/min had actual 24-hour creatinine clearance values ranging from less than 10 mL/min to more than 60 mL/min.

Although the Cockroft-Gault equation is still useful to obtain a ballpark estimate, when a true assessment of creatinine clearance is important for an individual patient, a 12- or 24-hour urine collection is still the preferred measure of renal function. The MacArthur Foundation Study of Successful Aging, in their evaluation of this issue, studied 15 equations (including the Cockroft-Gault equation) for potential use in estimating creatinine clearance accurately in the elderly.[3] To quote their findings and conclusions:

> Most equations underestimated creatinine clearance, with average bias ranging from −33.1 mL/min to +19.6 mL/min. . . . Equations were variable in their erroneous placement of individuals into renal junction categories. Regression modeling . . . failed to provide better estimates of creatinine clearance than those already available. . . . The equations evaluated here provide unacceptable predictions of creatinine clearance in normally aging individuals. We advocate the use of serum drug concentration measurements when available and encourage investigation into timed urine collections of short duration as alternatives to clearance-estimating equations in the elderly.

Of course, the authors' major point, that considering age-related changes in renal function when determining drug dosages, remains unchallenged. My caveat is to be wary of the quick estimates.

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References

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2. Fliser D, Bischoff I, Hanses A, et al. Renal handling of drugs in the healthy elderly. Creatinine clearance underestimates renal function and pharmacokinetics remain virtually unchanged. Eur J Clin Pharmacol 1999;55:205–11.
3. Malmrose LC, Gray SL, Pieper CF, et al. Measured versus estimated creatinine clearance in a high-functioning elderly sample: MacArthur Foundation Study of Successful Aging. J Am Geriatr Soc 1993;41:715–21.

Providing Medication by Bending the Rules

To the Editor: Physicians sometimes falsify records to help their patients.[1] Often such falsification is done at the behest of the patient. In one not-too-uncommon scenario, uninsured patients ask physicians to write the name of an insured relative on their prescription; the cost of the medicines will then be paid by the relative's insurance! To help indigent patients get urgently needed medicines, one author has even endorsed such practice.[2] I wish to highlight some caveats with this practice.

First, falsification is ethically and legally wrong. Second, the insurer can claim fraud. The activity might be reported by the patient (acting as an undercover agent) or a disgruntled employee. The medical board might discipline the physician. Third, the relative might unwittingly take the medicine and suffer harm. Fourth, what medical record will the physician produce if sued for professional negligence. Fifth, no major societal change will result from playing Robin Hood (sharing the insurer's wealth with the uninsured) on such a small scale. Finally, by not telling the truth, we will simply perpetuate society's ills by encouraging the patient to try more lies. The next time the trickster might ask the physician to see him at no cost and bill the relative's insurance! No matter what some people say, society still holds physicians in high esteem and will follow the example its role models set.

Most prescriptions cost less than $100. If physicians really want to help, it would be far better for them to buy the medicines from the neighboring pharmacy (one hopes at a professional discount) and dispense them at no cost to the patient. The patient could actually pick up the