Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is 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.

Management of Streptococcal Pharyngitis

To the Editor: The article "The Effects of the Rapid Strep Test on Physician Management of Streptococcal Pharyngitis"[1] has the admirable goal of studying actual practice. As family physicians "in the trenches," our most valued information is that which helps us care for our patients in real practice settings.

In that spirit, we should evaluate the rapid strep tests in light of our goal of treating patients with pharyngitis, rather than treating streptococcal pharyngitis. A test cries to be used, and the universe of tests available can easily define what diseases are considered.

The current rapid strep tests all suffer from the ability to detect only group A streptococcus. Other groups of streptococcus are pathogenic causes of pharyngitis, including group G[2] and group C.[3-5] Mycoplasmal and atypical organisms continue to be implicated as causes of sore throat.[6] The study by Corson, et al.[5] documents group C streptococcus as a more common cause of symptomatic pharyngitis than group A streptococcus.

My opinion is that the rapid strep tests have no place in day-to-day clinical practice. It is technically fascinating that the rapid strep tests work, but why use a test that identifies less than one-half of the treatable organisms? Those who persist in using the rapid strep tests should obtain a culture for patients with a negative rapid strep test.[7,8]

Floyd L. McIntyre, M.D.
So. Dennis, MA

References

1. Bryars CH 3d, deGruy FV, Dickinson LC, Waller AM. The effects of the rapid strep test on physician management of streptococcal pharyngitis. J Am Board Fam Pract 1991; 3:139-43.
2. McCue JD. Group G streptococcal pharyngitis. JAMA 1982; 248:1333-6.
3. Turner JC, Hayden GF, Kiselica D, Lohr J, Fishburne CF, Murren D. Association of group C beta-hemolytic streptococci with endemic pharyngitis among college students. JAMA 1990; 264:2644-6.
4. Meier FA, Centor RM, Graham L Jr, Dalton HP. Clinical and microbiological evidence for endemic pharyngitis among adults due to group C streptococci. Arch Intern Med 1990; 150:825-9.
5. Corson AP, Garagusi VF, Chretien JH. Group C beta-hemolytic streptococci causing pharyngitis and scarlet fever. South Med J 1989; 82:1119-21.
6. King DE, Muncie HL Jr. High prevalence of Mycoplasma pneumonia in patients with respiratory symptoms. A rapid detection method. J Fam Pract 1991; 32:529-31.
7. Wiedermann BL, Schwartz RH, McCoy P. Experience with rapid latex agglutination testing for group A streptococcal pharyngitis in a pediatric group office laboratory. J Am Board Fam Pract 1991; 4:79-82.
8. Redd SC, Facklam RR, Collin S, Cohen ML. Rapid group A streptococcal antigen detection kit: effect on antimicrobial therapy for acute pharyngitis. Pediatrics 1988; 82:576-81.

Cognition Dysfunction

To the Editor: While Rizzolo and colleagues have enumerated well the possible advantages of diagnosing dementia early through cognitive function screening, they have omitted some important potential disadvantages.[1] The mere labeling of a person as cognitively impaired risks creating barriers to health care beyond those that are strictly economic. Institutions and health care providers are often reluctant to manage the complex issues surrounding a dementing illness. Feeling the stigma of such a label, those so identified may avoid beneficial diagnostic evaluation and management. These are among concerns that place the value of this screening maneuver in doubt. In considering these issues, the Canadian Task Force on the Periodic Health Examination recently concluded that, "There is insufficient evidence to include routine screening for cognitive impairment in or exclude it from the periodic health examination of people over 65 years of age."[2]

Also, the authors have overstated the proven value of comprehensive geriatric assessment following a positive screening test for cognitive impairment. While some difficult cases identified in this manner may require a global assessment, these are not likely to be found at the local health fair. The benefit of geriatric evaluation has been reported in other limited contexts, not in the community-dwelling elderly and certainly not in those targeted simply because of cognitive impairment.[3]

Finally, by implying that interpretation of and follow-up after cognitive screening is primarily the realm of geriatricians, the authors ignore the capable and imperative role of community-based physicians in the diagnosis and management of dementing illness. While selected problems require the geriatrician's expertise, the very demographic factors they have mentioned will make referral more