resuscitation could be continued. The visiting nurse presented the discharge orders from the hospital indicating the DNR order signed by a physician, but this document was not deemed valid by the EMS crew. Frantically the resident was called to try to convince them to stop, but the EMS crew would not talk to him because they said they could not recognize a verbal order from this physician.

The patient's body was transported to a different hospital from that initially intended because of her "critical status," and the attempt at resuscitation was continued in that emergency department. The family followed and were prevented by hospital security from seeing the patient. Resuscitation efforts were stopped only when the resident was able to reach the emergency department physician by telephone, explain the situation, and ask for resuscitative efforts to be stopped.

Some states including Maryland have guidelines to try to ensure that situations such as the one described here do not occur. The policies of individual states in this regard are outlined in a paper by Sachs, et al.[2] following a survey of state EMS offices. Emergency services are also becoming increasingly aware of the problem.[3] The new Patient Self-Determination Act, which has recently been put into effect, even though it pertains only to institutionalized patients, should also increase awareness of this important issue.

I would be surprised if others among your readers have not encountered similar difficulties, and I would encourage dialogue with local EMS offices to try to ensure resolution of the problem.

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References

1. Daly MP, Sobal J. Advanced directives among patients in a house call program. J Am Board Fam Pract 1992; 5:11-5.
2. Sachs GA, Miles S, Levin RA. Limiting resuscitation: emergency policy in the emergency medical system. Ann Intern Med 1991; 114:151-4.
3. Hall S. New act compels EMS to define new roles. J Emerg Med 1992; 17:19-20.

Diagnosis of Multiple Myeloma

To the Editor: The recent *Journal* article by Keenan, et al.[1] highlights several pitfalls in the diagnostic use of bone scans. Another important weakness of the bone scan is its inability to detect multiple myeloma. Reliance on the bone scan to exclude boney involvement by myeloma can lead to the disastrous complication of spinal cord compression, which can occur in 15 percent of patients with myeloma and often happens early in the course of the disease.[2]

Bone pain is the most common symptom in multiple myeloma,[3] and the patient's family physician might use a bone scan as part of the evaluation. The technetium 99 used in many bone scans is taken up by the osteoblasts but not the osteoclasts. Most destructive lesions of bone are associated with osteoblastic attempts at repair, but the bone lesions in myeloma are lytic and rarely associated with new bone formation.

Unfortunately, plain radiographs also are not 100 percent sensitive for myeloma. In perhaps one-quarter of myeloma patients, circumscribed defects can be absent, and in some patients the plain films can be essentially normal.[4] Magnetic resonance imaging (MRI) might provide greater detail on myelomatous abnormality in the vertebral column than conventional radiographs.[2]

The common occurrence of low back pain in primary care precludes the casual use of an expensive and cumbersome procedure such as spinal MRI, but for optimal patient care, the family physician should continue to consider such uncommon illnesses as vertebral osteomyelitis and multiple myeloma in back pain patients.

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References

1. Keenan WF Jr, Fedullo LM, Robb ME, Plotkin GR. The bone scan in primary care: diagnostic pitfalls. J Am Board Fam Pract 1992; 5:63-7.
2. Salmon SE, Cassady JR. Plasma cell neoplasms. In: Devita VT, Hellman S, Rosenberg SA, editors. Cancer, principles and practice of oncology. 3rd ed. Philadelphia: J.B. Lippincott, 1989:1853-95.
3. Longo D. Plasma cell disorders. In: Wilson JD, Braunwald E, Isselbacher KJ, Petersdorf RG, Martin JB, Fauci AS, et al., editors. Harrison's principles of internal medicine. 12th ed. New York: McGraw-Hill, 1991:1413.
4. Paul LW, Juhl JH. The essentials of roentgen interpretation. 3rd ed. New York: Harper and Row, 1972:218.

Nursing Home Patients

To the Editor: Dr. Richard Waltman[1] of Tacoma, Washington, provided readers with a poignant editorial in the January-February issue of *JABFP*. He upbraided family physicians — especially young ones — for declining to see patients in nursing homes.

Dr. Waltman compared the exercise of this freedom with possibly declining to see patients of certain ethnic or racial origins, suggesting that such a decision should "cost the physician his or her medical license."

Obviously there is no comparison here. To have privileges in a nursing home, a physician must comply with rules of attendance, record-keeping, making rounds, and other specific regulations. In fact, the nursing home or a regulatory body can prohibit a physician from attending patients in a nursing home for failure to adhere to strictly imposed regulations.

It seems reasonable for any physician to decline to enter this regulatory morass. In his editorial, Dr. Waltman points out the reasoning for this: "Reimbursement is poor, demands are substantial, and the