

# 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.

## Cardiovascular Risk in a Mennonite Community

*To the Editor:* It was with great interest that I read "Cardiovascular Risk Factor Status of an Old Order Mennonite Community."<sup>1</sup> I am a native of Yates County, NY (the location of the study), a graduate of SUNY-Buffalo School of Medicine (the institution of the faculty who conducted the study), and I am board certified in family practice. When I was a medical student, I did a clinical rotation in the rural family practice of one of the authors (Dr. Rosenthal). To say that this study hit home is an understatement!

I believe that the investigation by the authors was very thorough and informative. I was struck by one statement, however. The authors stated that "Participants were also supplied with a list of community physicians available for follow-up care." I am occasionally in touch with physicians and hospital staff "back home" in Yates County. It is my understanding that all primary care practices are closed to new patients and have been for some time. One local physician will soon retire, and another is leaving to pursue administrative medicine. By all measures the county is underserved in both primary and specialty care. Even though it is an area of pastoral beauty with a well-respected rural hospital and within 90 minutes or less to three academic medical campuses (Rochester, SUNY-Upstate Syracuse, and Binghampton campuses), Yates County, NY, cannot attract enough physicians.

Defining the health needs of special rural populations is important, but it will be for naught if rural communities cannot attract primary care physicians to serve those needs. Yet I, a native of this rural area so in need of physicians, presently live in an urban area where the ratio of physicians to population has been reported as 1:90. My personal reasons for this are not as important as the glaring inequity in access to care that it ascertains.

The Mennonites are wonderful people of extreme integrity, as are others I've known in Yates County. They deserve access to state-of-the-art health care, as do all rural populations. I believe that, like myself, many young family physicians would be overjoyed to

raise their families in more rural environs if lifestyle (i.e., time with family) and income could even approximate that found in more urban practices. Instead of working in a rural area, I cling to the hope of retiring to one.

I believe that academic family medicine can assume leadership within the nation's emerging health care system if, after needs are defined, aggressive and novel solutions to bring physicians to less served populations are rapidly instituted and profoundly successful. The study by Michel, et al. reiterates the need for a national political and academic policy to address the lack of access to medical care in rural areas.

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## References

1. Michel A, Rosenthal TC, Crawford M. Cardiovascular risk factor status of an old order Mennonite community. *J Am Board Fam Pract* 1993; 6:225-31.

## Nondiagnostic Colposcopy Findings

*To the Editor:* The recent article "Frequency of Nondiagnostic Findings on Colposcopy: Implications for Management"<sup>1</sup> portrays nicely some of the pathologic findings encountered before and following colposcopy examinations in a family practice clinic. The large number of normal (21.7 percent) and nondiagnostic (29.7 percent) biopsy findings can be expected either in colposcopy clinics with liberal or low threshold referral criteria or where many of the colposcopists are on the early segments of the learning curve. In defense of the authors' high rate of normal histologic findings, a certain number of normal biopsy specimens should always be anticipated so as not to miss important cervical disease.

The dilemma of nondiagnostic findings suggested by the authors, however, must be further addressed by adherence to the central tenet of colposcopy. The correlation of not only the cytologic with the histologic findings, as pointed out by the authors, but also necessary correlation with the colposcopic impressions is essential to determine medically effective patient care. Unfortunately, the authors have excluded this very important element, the colposcopic impression, from the report. Therefore, any meaningful attempt to determine the significance of nondiagnostic biopsy reports is scientifically futile.

When the colposcopist evaluates abnormal cytologic results, colposcopic evidence of disease is either observed or not visualized. A dilemma might exist when an explanation for severely abnormal cytologic results cannot be readily appreciated. When what appears to resemble disease is colposcopically seen,

then the colposcopist must determine whether the abnormal colposcopic findings represent disease and, if so, the expected severity of the disease. Many abnormal colposcopic signs are also frequently observed in normal tissue. For example, the colposcopic distinction of atypical squamous metaplasia from low-grade premalignant disease might be quite difficult to determine because of similar appearances.

A colposcopic impression will guide management of nondiagnostic pathology laboratory results. If there is no evidence of cervical cancer or serious premalignant disease by colposcopic examination, then the meaning of the equivocal histologic results are placed in proper perspective. Otherwise, microbiologic testing, hormonal evaluation, and query into use of chemical or mechanical devices might assist in the evaluation of minimally abnormal results, as the authors indicated.

A hasty biopsy based only on a single abnormal colposcopic sign increases the number of nondiagnostic histology results, particularly in conjunction with minor cytologic changes. For example, the erroneous practice to biopsy "everything white" is fraught with an expected number of normal or nondiagnostic reports. The colposcopist must attempt to identify the tissue properly before a biopsy by formulating a colposcopic impression, just as the hunter must carefully identify the target so as not to "shoot anything that moves."

A sound practice of medicine is to use laboratory reports to confirm or reject the working diagnosis or clinical impression generated by the physician. Colposcopy is no different in this respect. Clinical colposcopic skills of cervical pathology assessment must counterbalance laboratory findings. A colposcopic impression is imperative to correlate with the cytologic and histologic findings and hence determine appropriate patient management.

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## References

1. Nuovo J, Kreiter L. Frequency of nondiagnostic findings on colposcopy: implications for management. *J Am Board Fam Pract* 1993; 6:209-14.

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

*To the Editor:* I appreciate the response from Dr. Ferris regarding the recent publication on nondiagnostic findings on colposcopy. I am in agreement with his statement that a colposcopic impression is an integral

part of an assessment of each patient who presents for a colposcopic evaluation of an abnormal Papanicolaou smear. Included in this assessment is an interpretation of the cytologic, histologic, and colposcopic findings. The goal of this manuscript was to focus on one aspect of this process. Our findings indicated that in our clinic nondiagnostic colposcopic biopsy results occurred frequently and that the meaning of these equivocal results was unclear. Based on my experience, I believe that our experience with nondiagnostic findings is similar to the experience of other colposcopy clinics. It is clear that further work needs to be done to answer the many questions that arise on the management of such patients.

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## Corrections

### Acute Otitis Media in Adults

As the result of misunderstanding between the editorial office and the authors of the recent paper "Acute Otitis Media in Adults: A Report from the International Primary Care Network," (Volume 6, Number 4, pp 333-9), the list of authors was incomplete. The principal investigators and international coordinators of this large international collaborative research study were Larry Culpepper, MD, and Jack Froom, MD. Twelve other authors were involved as country coordinators in nine participating countries. Accordingly, the authorship of this study was as follows: Larry Culpepper, Jack Froom, A.I.M. Bartelds, Peter Bowers, Charles Bridges-Webb, Paul Grob, Inese Grava-Gubins, Larry Green, Jacqueline Lion, Walter Rosser, Bertino Sormaini, A. Stroobant, Rae West, and Yair Yodfat.

### Steroid Use among Junior High School Students

In the "Results" section of the abstract (Volume 6, Number 4, p 341), the first sentence should read "There were 4.7 percent of the male students and 3.2 percent of the female students who admitted to using steroids."

### Osteitis Pubis

In the article "Osteitis Pubis" by Chris Vincent, MD, (Volume 6, Number 5, p 493) figures 1 and 2 were interchanged. *JABFP* sincerely regrets the error.