emphasized.[3] To provide support from the medical literature regarding the struggles faced by obstetrics-capable family physicians, the AAFP has compiled a bibliography that describes the data derived from the world's medical literature. This bibliography is available from the Huffington Library at the AAFP. These data can be helpful to family physicians seeking to provide objective information to hospital credential committees and others.

The recently published letter by Larimore[4] further documents the resurgence of obstetrics-enhanced family practice. I am pleased that some of my previous published material was cited. Reference 7 in the Sakornbut and Dickinson article was actually published in *Family Practice — An International Journal*.[5] This small typographic point should be noted for accuracy. Overall it does not detract from the contributions made by these authors and your journal in providing important data and support for family physicians who wish to deliver babies.

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References

1. Sakornbut EL, Dickinson L. Obstetric care in family practice residencies: a national survey. J Am Board Fam Pract 1993; 6:379-84.
2. Rodney WM. Obstetrics enhance family practice: an endangered species worth saving. Florida Fam Phys 1993; 53(1):18-9.
3. *Idem*. A personal reflection from the AAFP Task Force on Obstetrics. Tenn Fam Phys 1990; 1(3):4-5.
4. Larimore WL. Obstetrics in family practice [letter]. J Am Board Fam Pract 1993; 6:525-6.
5. Rodney WM. OB malpractice fee phobia among medical students in the United States. Fam Pract 1986; 2:113-6.

Cholesterol Screening

To the Editor: Dr. Frame's recent article "Screening and Management of Cholesterol Levels in Children and Adolescents"[1] and the accompanying editorial by Dr. Grumbach[2] provide a refreshing dose of common sense on the issue of cholesterol screening. It is regrettable that the United States embarked on a mass screening policy before having demonstrated benefit to our people (as opposed to just our coronary arteries). Intervention studies have consistently failed to demonstrate overall benefit to study groups, and no benefit to the health of children or young adults (as opposed to change in laboratory values) has ever been shown. It seems that we have confused the observation that a lower cholesterol value correlates with less frequent coronary artery disease (well demonstrated) with proof that lowering cholesterol will lower incidence of coronary artery disease in the general population (only shown in groups with average cholesterol levels of 265 mg/dL or greater). Much of the medical profession seems to ignore the oft-repeated finding of no net benefit in morbidity and mortality in treated groups of otherwise healthy persons. How can family physicians justify cholesterol screening in the absence of evidence of its efficacy for most individuals?

Of course, there are groups, such as those with known coronary artery disease or with familial disorders of lipid metabolism, who benefit from aggressive cholesterol reduction. However, those benefits are achieved with step 2 diets and medication intervention. Only these interventions (and surgical removal of parts of the bowel) have been shown to lower both coronary and overall morbidity and mortality, and then only in those with known coronary artery disease.

The issue of cholesterol screening in all populations is germane as we debate new financing schemes for health care in America. Here is one instance where we could learn from those with a national health system. The Canadians and British have both concluded that screening for and treating values of serum cholesterol below 265 mg/dL are just not worth it.

Family physicians are oriented to preventing as well as treating disease. The possibility of reducing risks for our patients, so successfully achieved through national initiatives on smoking cessation and hypertension, has, I submit, lured us into adopting a cholesterol-lowering national campaign without evidence that it could (let alone would) work. It is time for us to step back, reassess the data, and consider whether the effort and resources involved in this campaign could not be better spent on other strategies to improve our patients' and the nation's health.

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References

1. Frame PS. Screening and management of cholesterol levels in children and adolescents. J Am Board Fam Pract 1993; 6:582-7.
2. Grumbach K. Cholesterol: to screen or not to screen, that is the question. J Am Board Fam Pract 1993; 6:607-9.

Treatment of Black Widow Spider Bite

To the Editor: The treatment described in Zukowski's report of 2 patients with black widow spider envenomation[1] typifies what I believe to be common misconceptions about the therapy for black widow envenomation — the overreliance on calcium therapy and the underutilization of specific antivenin.

The role of calcium in the diagnosis and treatment of black widow spider envenomation has evolved largely from anecdotal experience. No controlled study has been performed to determine optimal treatment. While a dramatic response to calcium is seen in some patients, failure to respond does not exclude the diagnosis. In one of the few prospective studies on the subject, Key[2] found calcium effective in only 6 of 13 patients. Only 1 of 6 patients with the most

serious signs of envenomation responded to calcium administration. Several retrospective studies showed an inconsistent response to calcium as well.[3,4] Pain relief with calcium was often transient, requiring repeated injections as was described in 1 of Zukowski's 2 patients.

Specific antivenin has been consistently shown to provide rapid and lasting relief of symptoms. Most patients respond dramatically to a single 2.5-mL vial. Antivenin is used much more liberally in other parts of the world where early use of antivenin has been shown to reduce considerably the length of hospitalization and prevent the development of lingering neurologic dysfunction seen in some patients not treated with antivenin.[5,6] The risk of immediate hypersensitivity reaction from the horse-serum–derived antivenin can be reduced by sensitivity testing before administration. A serum sickness reaction might occur but is usually mild.

Calcium should be considered an adjunctive therapy while preparing for antivenin administration in patients with serious envenomation. Reliance on repeated doses of calcium is often ineffective, delays definitive antivenin therapy, and could predispose to increased morbidity and in rare cases mortality.

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References

1. Zukowski CW. Black widow spider bite. J Am Board Fam Pract 1993; 6:279-81.
2. Key GF. A comparison of calcium gluconate and methocarbamol (Robaxin) in the treatment of latrodectism (black widow spider envenomation). Am J Trop Med Hyg 1981; 30:273-7.
3. Moss HS, Binder LS. A retrospective review of black widow spider envenomation. Ann Emerg Med 1987; 16:188-92.
4. Timms PK, Gibbons RB. Latrodectism—effects of the black widow spider bite. West J Med 1986; 144:315-7.
5. Maretic Z. Latrodectism: variations in clinical manifestations provoked by *Latrodectus* species of spiders. Toxicon 1983; 21:457-66.
6. Sutherland SK, Trinca JC. Survey of 2144 cases of redback spider bites: Australia and New Zealand 1963-1976. Med J Aust 1978; 2:620-3.

The above letter was referred to Dr. Blackman, who offers the following reply:

To the Editor: We currently use antivenin in children, pregnant women, the elderly who are at high risk for hypertensive crisis and respiratory symptoms, and those with severe pain. In somewhat minor cases, our patients have been responsive to calcium gluconate and have not required antivenin. I agree with Dr. Miller that we are probably underutilizing antivenin. Similar debate goes on with the use of antivenin for the treatment of poisonous snake envenomation, and most of us believe that use of antivenin is warranted and its side effects can be appropriately treated, both acute anaphylaxis as well as chronic serum sickness. Controversies about the use of antivenin will occur until a new antivenin appears, either a pure IgG preparation from horse serum or, even better, a Fab fragment. It is hard to say when this will happen.

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Prolonged Delirium Tremens

To the Editor: I have some comments regarding the early management of the 67-year-old patient described in "Prolonged Delirium Tremens Requiring Massive Doses Of Medication" (*J Am Board Fam Pract* 1993, 6:502-4) by Wolf, et al.

The patient was a chronic alcoholic whose continuous drinking ended 3 days before he came to the emergency department. A physical examination showed disorientation, diaphoresis, tachycardia, tachypnea, tremulousness, brisk reflexes, ocular dysmetria, and spider hemangiomata. He subsequently decompensated further during the following 5 days "despite receiving up to 275 mg/d of oral chlordiazepoxide."

In my daily care of chemically dependent patients with acute alcohol abstinence syndrome in both a general community hospital and a community-based social detoxification unit, it is standard practice to give chlordiazepoxide in 100-mg doses at hourly intervals to maintain vital signs (Figure 1 shows a withdrawal scoring sheet — a score of 6 to 7 and higher usually requires medication). Although most patients require less than 500 mg of chlordiazepoxide total, it is not uncommon that a few will require from 1200 to 2400 mg of chlordiazepoxide in their first 24 hours of admission.

For elderly patients with heptic dysfunction, lorazepam has the advantage of renal excretion. In the nauseated or vomiting patient, lorazepam can be crushed and given sublingually. Lorazepam 5 mg by mouth or 1 mg sublingually can be given at hourly intervals in the place of chlordiazepoxide, but because of its short half-life, the drug must be tapered after the first 24 hours.

The alcoholic's recent drinking pattern, the time of the last drink, previous history of alcohol abstinence syndrome, age, and other medical conditions will give some clue as to how much medication will be needed to control the syndrome. The doses of benzodiazepine needed early to abort the progression from minor withdrawal to delirium are indeed massive when compared with the doses used elsewhere in the practice of clinical medicine. The alcoholic's tolerance is well established, however, and once a patient is "lost" to major withdrawal, it is very difficult to catch up. Extended hospital stays, cerebral dysfunction, and other morbidity, as well as mortality, is well known by those who care for the alcoholic.

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