Correspondence

We will 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 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.

Otitis Media in Adults

To the Editor: The excellent international report on otitis media by Culpepper, et al. published in *JABFP* (1993; 6:333-9) contains a finding which is discordant with the widely accepted assumption that antibiotic treatment is usually beneficial in the treatment of this disorder: in Table 6, patients who received antibiotics were reported, at the $P=0.002$ level, to do worse than those not so treated.[p 337]

I would greatly appreciate the authors of the study sharing any insights they might have about the reason(s) for this result. Were patients who received antibiotics different in some way from those who did not? Could the finding somehow reflect differences in the disease or in physician behavior from one nation to another? Or is antibiotic treatment somehow detrimental to the outcome of adult patients with otitis media?

Robert Gillette, MD
Youngstown, OH

The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: We are as interested as Dr. Gillette in our finding that antibiotic treatment of acute otitis media did not appear to be of benefit. This finding has been reported for children by other investigators as well[1-6]; however, we would not change clinical practice based on our results.

These findings could be the result of the design of our study. For it, volunteer family physicians and general practitioners in the nine participating countries were asked to enroll 15 consecutive patients visiting for acute otitis media. Within most of the countries involved, prescription of antibiotics at the initial visit was standard practice and occurred in more than 90 percent of cases. (There is considerable variability among countries in the duration of antibiotic treatment, with most reporting a 5- to 10-day treatment duration as the norm.) In Netherlands and Belgium, in large part because of the work of Dr. van Buchem,[4,6] patients with acute otitis media are routinely not treated with antibiotics at initial visit, although a small percentage do receive antibiotics as a result of their symptoms continuing for 3 or more days. Except for the samples of patients in our study enrolled in Netherlands and Belgium, the number of individuals not receiving antibiotics from other countries was few and insufficient to support treatment versus no treatment analyses at the individual country level. In comparing those who were not treated with those who were treated in Belgium and Netherlands, we found no indication that the severity of disease was significantly different or related to outcome. Similarly, in comparing these subgroups of Belgium and Netherlands patients with all those from other countries, we also found no indication of a difference in severity of illness. Although it is possible that unmeasured differences between the treated and untreated population did lead to the observed difference in outcomes, we have no indication of this based on the characteristics assessed.

Outcome at 2 months was determined either by physician examination, patient interview, or patient self-report. It is possible that the expectations of patients and physicians led to an increased perception of wellness in those not treated by antibiotic, or that our results might be due to other errors in the determination of outcome status. A further possibility is that, as patients in Netherlands and Belgium might be aware that they are likely not to receive an antibiotic at the first visit, the population presenting for care in these countries, and thus enrollment in our study, was different from those patients in the countries in which antibiotic treatment was routine. Again, we found no evidence supporting these possibilities in our data.

Currently we are embarking on an AHCPR-funded study comparing outcomes following acute otitis media in Netherlands (where antibiotics are not routinely prescribed at initial visit), England (where antibiotics are routinely prescribed for 5 days), and the United States (where antibiotics are routinely prescribed for 10 days). We will train participating physicians in the standard reporting of symptoms and physical findings and will use tympanometry as an objective measure of ear status both at enrollment and a 2-month outcome. This study should take advantage of the natural experiment possible because of routine differences in treatment practices, while decreasing the likelihood of measurement factors affecting the validity of results.

Larry Culpepper, MD, MPH
Pawtucket, RI
Jack Froom, MD
Stony Brook, NY

References

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2. Schwartz RH, Rodriguez WJ, Greindfast KM. Duration of middle ear effusion after acute otitis media. Pediatr Infect Dis J 1984; 3:204-7.

3. Cantekin EI, McGuire TW, Griffith TL. Antibiotic therapy for otitis media with effusion ('secretory' otitis media). JAMA 1991; 266:3309-17.
4. Van Buchem FL, Dunk JMM, van't Hof MA. Therapy of acute otitis media: myringotomy, antibiotics or neither? Lancet 1981; 2:883-7.
5. Mygind N, Meistrup-Larsen KI, Thomsen J, Thomsen VF, Josefsson K, Sorensen H. Penicillin in acute otitis media: a double-blind placebo-controlled trial. Clin Otolaryngol 1981; 6:5-13.
6. Van Buchem FL, Peeters MF, van't Hoff MA. Acute otitis media: a new treatment strategy. Br Med J 1985; 290:1033-7.

Prevention of Hepatitis B

To the Editor: The recent clinical review paper by Culpepper[1] on hepatitis B prevention was well done and satisfied many of my previously unanswered questions. Two more were raised by it, however.

Why not screen family members of adopted children who are positive for hepatitis B surface antigen (HBsAg) from endemic countries and potentially susceptible partners of the acutely infected before vaccinating or concurrently with beginning vaccination? As with bisexual or homosexual men and promiscuous women, such confirmation of susceptibility would avoid the costs of vaccinating the immune.

Second, the author associates continued HBsAg positivity 3 months after symptom onset with likely carrier status. He also remarks that incubation between exposure and symptom onset might be as short as 1 month, with infectivity and HBsAg positivity normally continuing 2 to 4 months. Evidently, he implies that one is infectious during incubation with the hepatitis B virus, as is the case with several other viral infections.

John Mosby, MD
LTC, MC

References

1. Culpepper L. Preventing hepatitis B: focus on women and their families. J Am Board Fam Pract 1993; 6:483-91.

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

To the Editor: Dr. Mosby raises two points that require further clarification. Most US families adopting HBsAg-positive children will be at low risk of having previously acquired the hepatitis B virus. Because of this, the majority will be susceptible. As with other new indications for immunization of previously low-risk individuals, the likelihood of the individual having previously contracted the hepatitis B virus is very small (in the range of 0.5 to 3.0 percent) and therefore such testing is not cost effective. For individuals, such as homosexual men and promiscuous women, who are at high risk of having previously contracted the hepatitis B virus, the yield is much higher, and confirmation of susceptibility before vaccination is cost effective.

With regard to the onset and duration of an individual being infectious, two points are important. First, an individual remains infectious as long as the hepatitis B virus is present in blood, semen, or other bodily secretions. The degree of infectiousness is related to the concentration of the hepatitis B virus. (Although testing for it usually is not indicated clinically, the presence of HBeAg is a marker for active viral replication and resultant high concentrations of hepatitis B virus.) Second, symptom expression during acute hepatitis B infections is highly variable. A great number of individuals have only minor symptoms and might never come to medical attention. When symptoms do develop, they often follow the initial presence of the hepatitis B virus (indicated by HBsAg positivity) by several weeks. Thus, an individual can be infectious for weeks before clinical recognition of the hepatitis B infection.

Larry Culpepper, MD, MPH
Pawtucket, RI

Unplanned Pregnancy

To the Editor: I am writing in response to an article written by Rosenfeld, et al. (Unplanned pregnancy: have family physicians used opportunities to make a difference? J Am Board Fam Pract 7; 1:77-9).

As a physician who has worked with other cultures, I suspect that the authors' frustration in changing the rate of "unplanned" pregnancies might be due to a lack of cross-cultural understanding.

The authors' cultural point of view is best described as logical: they seem to assume that women are in complete charge of their own lives, that decisions are made by logical criteria, and that reproductive choices are made logically: as if all women plan their pregnancies, that all women should plan their pregnancies, and that an unplanned pregnancy is an unwanted pregnancy. They even describe the emotional messiness of having babies as if it were a preventable disease "accompanied by emotional, social, and financial complications" rather than a somewhat illogical result of what is often a spontaneous emotional sexual act.

I suspect that their patients view life differently. Rather than a long-term, logical planning of their lives in terms of health, wealth, and success, many of the women we see exhibit a type of decision making associated with a short-term rather than long-term planning and a fatalistic approach to life. I suspect many of these women think that they have no control over their lives in matters of sex, jobs, or money problems; a baby might be viewed as an "act of God" — an unavoidable occurrence. Nevertheless, because they believe that fate (or God) is in control, they might be able to cope with a pregnancy despite medical, financial, and social problems — which is why one cannot assume that "unplanned" is synonymous with "unwanted" or even with "unexpected."

Indeed, the failure to use birth control, which too often doesn't work or is stopped because it "makes them sick," could be due to this fatalistic approach to life.

The bad effect of this mindset is the lack of initiative to improve their lives; the good effect is that these women cope with (or muddle through) a life that would