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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

daunt or destroy many of those who think they are in control of their lives.

Perhaps using family planning counselors from the same cultural background would increase the successful use of family planning.

I would also suggest training in medical anthropology or reading books, such as those by Robert Coles, which might shed a more sympathetic light on the culture and beliefs of patients.

Nancy K. O'Connor, MD
Ellensburg, PA

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

To the Editor: Dr. O'Connor is completely correct that the causes of "unplanned" pregnancies are complex, multifactoral and culturally based. We did not mean to imply that "unplanned" pregnancies were necessarily "unwanted"; in our practice and in the literature it is shown that many of these are "mistimed" and are often wanted once they occur. Many women do cope and succeed with these unplanned pregnancies; some do not.

Our study was one in a group of research projects planned to help discover ways women can take better control of their lives by assuming control of their reproductive functions. To this end, we explored one issue only — whether family physicians were providing the information about birth control at any opportunity they had so that the women could take control of their reproductive health, if they wanted to do so. Without information, women cannot choose whether to use it.

Obviously the area for further study is immense. Why women seek contraceptive advice, what they expect, what health and cultural beliefs affect these encounters and behaviors, what kind of information they receive, how they use it, and why all are issues that need careful investigation. We attempt to understand the cultural background of our patients in every encounter.

Jo Ann Rosenfeld, MD
Bristol, TN

Examination of Placenta after Twin Delivery

To the Editor: I was taken aback when reading the article about twin vaginal delivery after a previous Cesarean section by John P. Fogarty in the November-December issue (Twin vaginal delivery after a previous Cesarean delivery for twins. J Am Board Fam Pract 1993; 600-3). The item that really caused me to sit up and take notice was the line in the case report about the placenta being sent for pathologic evaluation. Lo and behold, it was determined that the twins were diamniotic-dichorionic! Why the unnecessary expense of sending the placenta? Earlier in the same paragraph, it was made clear that the mother delivered a boy and a girl. Perhaps the placenta was sent for other reasons, but determination of the chorion and amnion are usually reserved for same-sex twins to determine if they are identical. I also think it was terrific that the mother delivered twins vaginally after a Cesarean section. Congratulations on the successful delivery!

Janet Beck Jakupcak, MD
Marseilles, IL

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

To the Editor: I appreciate the concerns of Dr. Jakupcak. In this dynamic time of health care reform, attention to cost is an important issue. In this case, however, the patient did not bear any burden for this pathologic examination of the placenta. The delivery was performed at a busy military hospital with a large family practice residency training program. The placenta was examined as a matter of routine and to be complete in this academic setting. That the infants were of opposite sex might appear to obviate the need for this examination, but monozygotic twins might be discordant for phenotypic sex, and the examination of the placenta serves to identify zygosity more firmly than do later, more inconvenient and expensive tests.[1] I thank Dr. Jakupcak for her congratulations and enthusiasm about this fun and interesting case.

John P. Fogarty, MD
COL, MC

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Primary Care at a Crossroads

To the Editor: We are writing to share some commentary on the article by you and L. Gary Hart titled "Primary Care at a Crossroads: Progress, Problems, and Future Projections," which appeared in the January-February issue (J Am Board Fam Pract 1994; 7:60-70). Although we enjoyed the article and found it to be quite informative, we felt the need to comment on some important and pertinent problems that were not fully addressed.

By way of background, we are employees of the US Public Health Service in the Denver regional office (PHS Region VIII). We are responsible for oversight of the federal programs designed to provide primary health care services for the medically underserved in our six-state region (CO, MT, ND, SD, UT, and WY), which consists primarily of rural and frontier areas. Ms. Bailey is Director of the Division of Health Services Delivery, which oversees the regional activities of the federal government's Maternal and Child Health Bureau, the Office of Population Affairs (our family planning programs), and the Bureau of Primary Health Care (which includes the National Health Service Corps and the community and migrant health center program, among others). Dr. Babitz is a board-certified family physician who serves as the Regional Clinical Coordinator and Associate Division Director for Clini-