

bacteremia or, alternatively, 100 patients would need to be treated to prevent 9 from developing MAC bacteremia.

Concern about routine MAC prophylaxis continues. The study¹ and recommendations^{2,3} for routine MAC prophylaxis when the CD4+ lymphocyte count decreases to fewer than 100 cells/ μ L has led to debate about the role of MAC prophylaxis. The difference in CD4+ cell counts between patients in the control and the treated groups was significant ($P=0.01$).⁴ Although the study was designed to assess MAC prophylaxis for patients with fewer than 200 CD4+ cells/ μ L, the mean base-line CD4+ counts in both groups were less than 70 cells/ μ L.⁵ The cost of prophylaxis is considerable.⁵ There is also concern that drug resistance could be a potential problem in treating *M. avium* infection and, more importantly, *M. tuberculosis* infection.⁶ Reports of uveitis at higher dosages (600 mg daily or greater) than recommended for prophylaxis (300 mg daily) raise additional concern.^{7,8} Concomitant fluconazole therapy also raises the rifabutin serum concentration.⁹ To decrease the possibility of rifabutin toxicity when fluconazole is co-administered, rifabutin dosage reduction has been suggested, although no data are available to support this approach.

We continue to recommend offering MAC prophylaxis to patients with CD4+ counts fewer than 50 cells/ μ L. This recommendation is consistent with those of our pharmacy and therapeutics committee at San Francisco General Hospital. Providers and patients who wish to institute prophylaxis when CD4+ counts decrease to fewer than 100 cells/ μ L, as well as those who wish to bypass prophylaxis and treat only if active MAC occurs, can be assured that these options are equally acceptable.

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Practice of Obstetrics

To the Editor: The article by Greenburg and Hochheiser in a recent issue of the *JABFP*¹ and an editorial comment by Nesbitt² in the same issue reminded me of a study that I performed as part of the curriculum in the Faculty Development Fellowship Program in Family Medicine at the University of North Carolina in 1979-1980. Part of the course work involved doing a small research project.

For my research project I studied the attitudes of residents toward the future practice of obstetrics once they had completed their residencies. Without going into too many specific details, the conclusion of my study indicated that a far higher percentage of residents in military residency programs intended to practice obstetrics than did their counterparts in the civilian residency program. It appeared that the type of experience that residents had in their particular programs had a profound effect on this decision. In military programs all the attending physicians in the program were active participants in and practitioners of obstetrics. The same was not true in the civilian programs, where it was up to the attending physicians to choose whether they wanted to participate in obstetrics. Apparently, the enthusiasm or lack thereof played some role in the decision of the graduates to practice obstetrics.

I believe that the same situation still strongly influences graduates' decisions as to whether they intend to practice obstetrics. Of course, many other factors must be considered, but these factors have already been elaborated on in the article. Suffice it to say that if a program intends to encourage its graduates to practice obstetrics, then more than just lip service should be paid to this training. There should be a full commitment from the faculty to participate actively in the obstetric training and to help residents find ways to deal with obstacles that could arise when they choose their potential practice sites.

The introduction of the Advanced Life Support in Obstetrics (ALSO) course will add confidence to potential family practice obstetric practitioners and help them feel more comfortable about a future obstetric practice. This 2-day course in practical obstetric problem solving, based on the advanced cardiac life support (ACLS) format and taught by family physicians, provides an opportunity to fine-tune obstetric skills. Many residency programs are incorporating ALSO into their curriculum as the mood in the community swings toward the family practice obstetrician.

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2. Nesbitt TS. Family practice residents and future obstetrics practice. *J Am Board Fam Pract* 1994; 7:84-6.

Management of Dizziness

To the Editor: The recent publication by Sloane, et al.¹ on dizziness as it presents in primary care patients is a commendable effort to put an often-elusive symptom into useful clinical perspective. The authors could bring the study into sharper focus by replying to the following questions:

1. Dizziness (perhaps excluding vestibular vertigo) is a common manifestation of the frequently seen somatoform disorders.² Was this category of diagnosis entertained in any of the study patients?
2. Did the physicians who examined and treated the patients follow mutually agreed upon protocols for clinical examination, especially of the cardiovascular and central nervous systems?
3. Were there agreed standards for the diagnosis of disorders, such as sinusitis, or for deciding how severe a patient's hypertension or otitis media had to be before it could be accepted as a causative factor for dizziness?
4. Finally, it would be interesting and perhaps instructive to know whether, in hindsight, the 1 patient in the series with an acoustic neuroma had specific signs or symptoms that pointed to this diagnosis or whether the neuroma was a serendipitous finding.

Robert D. Gillette, MD
Youngstown, OH

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2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 3rd ed., revised. Washington, DC: American Psychiatric Association, 1987:255-67.

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

To the Editor: Dr. Gillette's questions highlight one of the most important questions that always concerns generalist physicians: are we making the right diagnosis in the primary care setting? This study was not designed to address that issue but rather the issue of describing what does happen in primary care. To propose diagnostic criteria for the more than 72 different conditions that can present as dizziness would have been to impose an extremely complex (and not necessarily more correct) process on our research. This was done by Kroenke, et al.¹ in a recent study, which — by virtue

of imposing a standardized work-up on patients — assured that they only studied persons with chronic dizziness. Our study was designed to take a broader look at primary care, not assuming that we had the answers, but instead describing what does occur in practice. Obviously there are many other studies that can and should be done, and Dr. Gillette has suggested an approach that is definitely worth considering for another study.

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1. Kroenke K, Lucas CA, Rosenberg ML, Scherokman B, Herbers JE Jr, Wehrle PA, et al. Causes of persistent dizziness. A prospective study of 100 patients in ambulatory care. *Ann Intern Med* 1992; 117:898-904.

To the Editor: I am very excited about the article by Sloane, et al. entitled "Management of Dizziness in Primary Care" (*JABFP* 1994; 7:1-8). The work-up of a dizzy patient can be extremely complex and is difficult to force into an elegant algorithm. I was sorry not to see more detail about the 19 patients with psychiatric diagnoses. I expect several of these patients suffered from anxiety or post-traumatic stress disorder connected with alcoholism in their families. I have uncovered a remarkable number of alcoholic families by asking the dizzy patient, "Does your spouse drink?" When the person answers "yes," I ask, "How much?" Of course, positive answers are "too much" or "all the time" or similar statements.

Inasmuch as the average alcoholic severely affects 4 other persons (most often nonalcoholic family members), it is not surprising to see patients with vague dizziness as a somatic manifestation of this family disease. It is still a struggle to decide how far to go with laboratory testing and other investigations on such patients. Codependant patients can have brain tumors, too. A good substance abuse history, not only of the patient but of the immediate family members, might save time, money, and lives.

H.E. Woodall, MD
Anderson, SC

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

To the Editor: Dr. Woodall's letter illustrates something about the diagnosis of dizziness. In a way, looking at dizziness is like the blind man and the elephant: whatever you look for you see, and everyone sees something different. Dr. Woodall's comments point out how broad the differential diagnosis is, and what a challenge it is for primary care physicians to find the true cause.

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