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 quarterly journal where continuity of comment and redress is difficult to achieve. When the redress appears 3 months after the comment, 6 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.

Nonsteroidals in Elderly

To the Editor: I believe that publication of the article "Office-Based Evaluation Of Renal Function In Elderly Patients Receiving Nonsteroidal Anti-Inflammatory Drugs" by Cummings, et al. (April–June 1988 issue) was premature and misleading. The content of the report presumes to show that ibuprofen 400 mg qid had no more effect on renal function than aspirin 650 mg qid in an elderly population for a 6-week test period and that neither drug caused progressive renal impairment. The authors admit that relatively insensitive measures were used due to procedural difficulties. The title of the article suggests that it is about office-based methods of assessing renal function, not an attempt to prove that ibuprofen is safe. This and the fact that the study was supported by the Upjohn Company, a major manufacturer of ibuprofen, further brings this study into question. In the very least, the data should not have been accepted for the publication until a longer study had been done with a placebo group and a greater sample size and with more sensitive measures of renal function employed.

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Editor's Note

This letter is deeply appreciated by the editors. This article or any article published is subject to thoughtful criticism. It is the willingness to point out perceived shortcomings of manuscripts and editors that is needed to maintain and improve the quality of the publication.

Gestational Diabetes

To the Editor: Zoller, et al. are to be commended for their study on "Screening for Gestational Diabetes."[1] With a prospective trial, they showed that traditional risk factors for diabetes are not sensitive or reliable in predicting which pregnant women will have a positive glucose tolerance test. They also showed that the 1-hour, 50-gram glucose challenge test is a highly sensitive and cost-effective screening test for detecting those with gestational diabetes and recommended its universal application in prenatal care.

The study by Zoller, et al. validates current recommendations in the screening for gestational diabetes.[2] If one accepts this approach as optimal care, there is no problem. However, I have questions and concerns about the impact on normal women with the universal application of glucose challenge testing.

As in previous studies, Zoller, et al. had a high false-positive rate with glucose challenge testing (15 percent of the study group were positive, and about 5 out of 6 women who were positive were not diabetic by the glucose tolerance test). Because the standardized oral glucose tolerance test is such an unpleasant experience for pregnant women (many vomit the solution), there is a real tendency in practice to omit the test and make the diagnosis of gestational diabetes simply on the basis of a positive screening test.[3] Such practice would result in massive overdiagnosis of gestational diabetes and seriously compromise the ability of many women to have a normal spontaneous delivery without medical intervention. Even with the proper diagnostic approach, I have seen women with positive screening tests label themselves as possibly diabetic, and they are considered as such by health care providers.

Is there a better and more practical approach for the screening and diagnosis of gestational diabetes? With the widespread availability of immediate fingerstick blood glucose, this test can easily be performed during prenatal visits. Fasting and post-meal blood glucoses could be obtained strategically during prenatal visits, and if they are high by standard criteria, more standardized post-prandial testing could be done. At least one study in England showed random blood glucose testing in pregnancy to be reliable and cost effective.[4]

Why do we rely on the oral glucose tolerance test as the "gold standard" for the diagnosis of gestational diabetes? Much of medicine has largely abandoned this test in favor of more physiologic fasting and post-meal testing.

Are all pregnant women with a positive glucose tolerance test at risk for the complications usually associated with diabetes in pregnancy? It is difficult to compare our current gestational diabetic population with that of O'Sullivan in the 1950s and 1960s when many more diabetics were not previously diagnosed. More current studies suggest that the only consistent risk factor for women with mildly elevated glucose is that their babies are larger (I refuse to label babies with a birth weight of 3808 g as macrosomic).[5]

The universal screening of pregnant women with a glucose challenge test seems like an example of a "maximum strategy in modern obstetrics" well described by Brody and Thompson.[6] Normal- or low-risk women can easily be victimized by an approach preoccupied

with detecting all possible abnormal patients. I hope researchers in family practice will lead obstetrical care to a more practical and specific approach to the diagnosis of gestational diabetes.

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Adoption

To the Editor: In the April–June 1988 issue, there is an article entitled "The Physician's Responsibility in Adoption, Part II," written by Carl and Lois Melina. I thought the article was very well written and pertinent.

The issue of informing an individual that he/she has been adopted still seems of great importance to me. I cannot understand why there is such a rush by so many these days to let individuals know that they have been adopted. It seems reasonable to me either to not inform the person or to delay the information until the child is at least 18 and more able to withstand the typical confusion and dismay that such news brings. I know of two cases in which children, who were told at an early age that they were adopted, suffered considerably because of the distrust and wonder that this information caused. Furthermore, unless there is some clearly important information about a person's genetic or other background to relate, I doubt that we should inform someone that he/she has been adopted.

Ignorance can indeed be bliss in some matters.

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Consultation/Referral Patterns

To the Editor: In a recent article, Vogt and Amundson[1] reported the results of their survey of North Central members of the American Academy of Family Physicians about referrals to internal medicine and pediatric generalists versus subspecialists. With regard to internal medicine consultation/referral, they documented a strong preference for referral to subspecialists as opposed to generalists. This was particularly true for residency-trained family physicians.

As a general internist who has taught full time in family practice residencies for the past 9 years, I am somewhat dismayed by these results. The role of the general internist has been widely debated in internal medicine circles. On the one hand, the general internist is viewed as an "adult medicine specialist" who would be better prepared to deliver primary care (in concert with pediatricians and obstetricians) than would the family physician.[2] On the other hand, the general internist is viewed as a diagnostic consultant who would have special and intensive training in the wide variety of technical procedures currently being performed by subspecialists.[3] I have previously participated in this debate and have suggested that there are at least three categories of adult patients who would be best referred to a general internist.[4] These categories are:

1. Patients who have multiple medical illnesses involving several organ systems, all of which are important and interrelated. The general internist's impartiality may be an advantage in looking at the total internal medicine picture.
2. Patients whose presenting complaints are nebulous or not easily categorized by organ system. This is a surprisingly common occurrence and once again benefits from the perspective of an unbiased generalist.
3. Patients in whom the family physician identifies a leading medical problem, possibly in a particular subspecialty, but in whom a more measured and less aggressive approach is desired. The generalist's cognitive skills may be more helpful than the subspecialist's procedural imperative.

There are other advantages of referral to a general internist. In complicated cases, three or four individual referrals to different subspecialists may be necessary to answer all of the family physician's clinical questions. This is difficult and confusing for the patient and his/her family, not to mention quite expensive. No reasonable physician would use several different drugs when one would suffice. Why should the principle be any different when choosing consultants? I suspect that initial referral to a subspecialist (who may feel insecure in evaluating questions outside his/her narrow field) is more likely to result in a pattern of secondary and even tertiary referral, often completely unknown to the originating physician. Such patients frequently become lost in a complex medical system for months at a time, returning to their family physician only after multiple aggressive interventions. This phenomenon resembles Michael Balint's *Collusion of Anonymity*. I believe that an initial referral to a general internist would less likely result in such fiascoes.

The authors correctly identify some of the factors influencing the referral choices of family physicians in