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.

Hyperlipidemia

To the Editor: Dr. Michael Crouch, in "Assessing and Managing Hyperlipidemia," concludes ". . . family medicine still has an opportunity to assume a leadership role in this area.[1] Dr. Crouch's excellent article attracted our attention. We would like to offer two opportunities where family physicians may participate in the nation's approach to hyperlipidemia.

Family physicians may participate in the Physicians' Cholesterol Education Program (PCEP) as providers. The American Heart Association PCEP was introduced in October 1987 in Washington, D.C. State affiliates are conducting seminars for primary care and other physicians on the new guidelines for cholesterol, as well as information on the physiology, diagnosis, and treatment of hyperlipidemias. The American Heart Association (AHA) cites family physicians as one of the principal target groups for its educational efforts.

A second opportunity for family physicians is to assist state AHA affiliates as physician trainers. Because family physicians are often experienced in patient education, they are naturals for teaching other family physicians and colleagues in cardiology, internal medicine, obstetrics and gynecology, and pediatrics about how to identify and care for patients with lipid disorders.

It is noteworthy that the American Heart Association's PCEP includes a strong section on patient education, which was developed by faculty at the University of California, San Francisco, affiliate residency program in Fresno.[2] Based on adult learning theory, the principles set forth will be familiar to those family physicians who have received training in health education during their residencies or elsewhere.

Again, congratulations to Dr. Crouch for an excellent summary article.

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Scuba Diver Standards

To the Editor: The review of diving medicine physiology by Dr. J. Thomas Millington (July–September 1988) is timely and will doubtless serve as a valuable source of information for the practicing clinician. There are several omissions that I would like to address.

Many physicians are unaware that there are organizations whose main impetus is diving medicine. The Undersea and Hyperbaric Medical Society, 2650 Rockville Pike, Bethesda, MD 20814, provides a list of physicians skilled in diving medicine, which may be useful to family doctors who have patients with medical problems that should be evaluated by a specialist in diving medicine.

In addition, Duke University has helped to establish the Divers Alert Network, a nationwide referral hotline for diving-related problems. In the event of a medical emergency, the Divers Alert Network maintains 24-hour emergency staffing and may be reached at 919-684-8111. Nonemergency diving-related questions can also be discussed with an authority in diving medicine; there is a daytime referral number (919-684-2948).

Second, there is a tendency to clear patients with potential disqualifications by suggesting that they dive in "shallow water only." As can be seen from the article, the effects of pressure on gas volume are not linear, and, in fact, the largest changes in volume occur between the surface and 10 feet of sea water. There is almost no circumstance where scuba diving with a such a limitation should be permitted because air embolism may occur in water as shallow as 4 feet if air trapping occurs.

Finally, physicians should be aware that they may be consulted by their patients who, when flying home from vacation in which they have been scuba diving, have symptoms referable to decompression sickness. Flying in an airplane after scuba diving can be complex, for the clearance of nitrogen gas changes dramatically when the person is suddenly exposed to the lower pressure of a commercial airplane. Physicians would be well advised to seek a diving history in those patients returning from vacations in which scuba diving may have been a possible recreational activity. "Resort courses" can allow persons without formal training in scuba diving to dive while on vacation without providing any significant amount of medical information, and the patient may be unaware of the source of his or her symptoms.

I trust that the physical standards for scuba divers as written by Dr. Millington will provide a useful basis for the rational evaluation and treatment of persons entering the scuba community.

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