COMMENTARY

Guest Family Physician Commentaries

Robert P. Jackman, MD

Re: Nasolaryngoscopy in a Family Medicine Clinic: Indications, Findings, and Economics

The study by Wilkins et al[1] clearly demonstrates the utility of performing nasolaryngoscopy (NLG) in the family medicine clinic. As detailed in their article, one can find an alarming rate of abnormalities (1.1% laryngeal cancer) and thus expedite any referrals to ear, nose, and throat (ENT) specialists. It is important that family medicine training include training for NLG, if possible, especially when residents plan on practicing in rural areas. In my town of Klamath Falls, OR, we have one ENT specialist; by performing NLG we can assist in ruling out non–life-threatening and easily treatable conditions without unduly burdening him with referrals. The cost analysis table is especially helpful in deciding if it is economically feasible to purchase a nasolaryngoscope and to determine the justification if one plans on asking for financial support to purchase the device.

We, as family medicine specialists, hope to serve our patients in as broad a capacity as possible, and by providing an easy-to-master procedure we can further aid our patients and provide a convenience to them. In my clinic, if I see a patient with an ENT "red flag"[2,3] (unilateral otalgia without otitis media, hoarseness, globus, etc) I can provide this service and potentially offer immediate reassurance or suggest further testing.

From Cascade East Family Practice, Klamath Falls, OR.
Funding: none.
Conflict of interest: none declared.
Corresponding author: Robert P. Jackman, MD, Cascade East Family Practice, Klamath Falls, OR 97601 (E-mail: RJackman@skylakes.org).

See Related Articles on Pages 591, 614, and 647.

Re: Assessing Safe and Independent Living in Vulnerable Older Adults: Perspectives of Professionals Who Conduct Home Assessments

As the population ages it is becoming increasingly important to provide quality care for geriatric patients. It is estimated that the number of people ages 65 to 84 years will increase 35% between the years 2010 and 2020.[4] Bearing this fact in mind, all primary care physicians will be caring for an increasing number of elderly patients. We will be asked more and more frequently to care for those who are homebound, vulnerable, and/or cognitively impaired. Therefore, we need to be aware of the services available to and needed by this segment of our patient populations. A familiarity with the social services available and the assessments and interventions that can be conducted by primary care physicians will become increasingly essential. The vulnerability assessment as outlined in the article by Naik et al[5] describes 5 components that are important to identify: (1) cognitive abilities, (2) judgment, (3) grooming, (4) environmental safety, and (5) activities of daily living. A common thread among these components is a need to enter the community and visit (either in person or by proxy) the patients—a home visit. Unfortunately, Naik et al's[5] study identified gaps in the way we currently assess our patients and a lack of appropriate tools for evaluating vulnerability and the capacity for safe and independent living. It has long been the tradition of physicians to visit their patients on their "home ground"; it may be time to resume doing so. If this fails, then improving coordination among nursing and community social service professionals becomes paramount.

Re: Lifetime Follow-up Care after Childhood Cancer[6]

As more and more childhood cancers are treated successfully, we as family medicine physicians will be faced with the consequences of treatments that can cause secondary cancer and other mor-

bidities. Whether or not we are comfortable treating these patients, they will show up in our clinics; thus, we need to be prepared to support them and their families through the hard and stressful treatment process. In rural areas or in areas removed from a tertiary care center, we may, under direction, be the ones providing certain treatments. For new patients (adults and children), a thorough medical history can alert one to the future possibility of a secondary morbidity. Any history of childhood cancer should serve as a reminder to be on the lookout for posttraumatic stress disorder related to the illness, fear and aversion of the health care system, and/or obesity or other physical changes associated with any previous cancer treatments. To holistically treat childhood cancer survivors, they and their illness must be placed into the context of their present state of being. In this way we can better serve our patients.

References

1. Wilkins T, Gillies RA, Getz A, Zimmerman D, Kang L. Nasolaryngoscopy in a family medicine clinic: indications, findings, and economics. J Am Board Fam Med 2010;23:591–7.
2. Ely JW, Hansen MR, Clark EC. Diagnosis of ear pain. Am Fam Physician 2008;77:621–8.
3. Rosen CA, Andersen D, Murray T. Evaluating hoarseness: keeping your patient's voice healthy. Am Fam Physician 1998;57:2775–82.
4. US Census Bureau. US population projections. National population projections, released 2008 (based on Census 2000): summary tables. Available at http://www.census.gov/population/www/projections/summarytables.html. Accessed on 4 July 2010.
5. Naik AD, Kunik ME, Cassidy KR, Nair J, Coverdale J. Assessing safe and independent living in vulnerable older adults: perspectives of professionals who conduct home assessments. J Am Board Fam Med 2010;23:614–21.
6. Haddy RI, Haddy TB. Lifetime follow-up care after childhood cancer. J Am Board Fam Med 2010;23:647–54.