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Editor's Comment

I sincerely appreciate the comments of Drs. Jack and Culpepper and stand corrected regarding my factual errors. However, I suspect I am not alone in misinterpreting the public information, which was provided through the media. This explanation helps me to feel much more positive about the suggestions of the Expert Panel. Nevertheless, I continue to be haunted by a palpable uneasiness about prenatal care in this country. I share the hopes and aspirations of the Panel and applaud their efforts.

Paul R. Young, M.D.
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Mammography

To the Editor: Dr. Foley, et al. report an increase in the performance (from 35 percent to 45.2 percent) of mammography in a hospital-based family practice teaching service as the result of a nurse-initiated intervention.[1] Theirs is one of the few studies to have reported physician offer rate, and for this they are to be commended. They state that, unfortunately, less than 50 percent of eligible patients had mammography recommended. From this comment, and the 45 percent performance rate, it appears that patient refusal was a minor factor.

An important observation made in their article was that one barrier to physician offer of mammography was "meeting the patient for the first time or treating the patient for an acute unrelated problem." In light of this comment, it is unfortunate, therefore, that they purposely eliminated this group of patients from analysis in their study. Of the 387 postintervention charts available for analysis, they eliminated 117 (30 percent) because they did not meet the criteria of being "an established patient receiving continuity of care at the health center." It would be interesting to know the screening experience of the new or episodic patients who appear to compose one-third of their practice. I would guess that screening activity for this group is not very good.

I would agree with the authors' expectation that the proportion of eligible women having mammograms recommended will increase after their intervention has been in operation longer. I suggest that they, and all of us, extend our concept of eligibility to *all* women, including those patients seen infrequently or for the first time.

David L. Hahn, M.D.
Madison, WI

References

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The above letter was referred to the authors who offer the following reply:

To the Editor: Dr. D'Amico, Dr. Merenstein, and I fully agree with Dr. Hahn's suggestion that all of us, as physicians, extend our concept of mammogram eligibility to include all women whether regular patients, first-time patients, or infrequent patients. This concept would be a noble objective for all screening tests. Unfortunately, strict adherence would still leave large segments of the eligible population unscreened, i.e., those who seek medical care rarely (but often need it more) for whatever reasons. Extending screening to this population is a public health issue of great magnitude.

For our study, using regularly established patients offered the advantage of having past mammography information and more reliable follow-up than had we included first-time or infrequent patients. Because of this, we improved our ability to measure a change because of the intervention. While analysis of the excluded 117 charts would be interesting, the true impact of the intervention could not be measured in this unestablished population because of so many uncertainties. Most importantly, we were unsure whether these patients would be returning and available for follow-up.

Another justification for excluding nonestablished patients is that we wanted to conduct our study in such a way that it was representative of a family practice and the continuity of care, which is at the very foundation of family practice. If family physicians maximize their abilities to offer preventive care, this practice is likely to reap its biggest rewards for patients with established doctor-patient relations.

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Esophagogastroduodenoscopy

To the Editor: It was with great interest and excitement that I read the report of Rodney, et al. about "Esophagogastroduodenoscopy by Family Physicians" (April–June 1990). I differ from these gentlemen in that I was trained in this procedure during residency. My excitement stems from the realization that I am far from alone in our specialty in my performance of EGDs.

My interest is in a notable exception from the list of indications given in Table 2. It seems remarkable to me that in over 700 procedures not one was performed for the work-up of GI bleeding. This has been listed as the primary indication for this procedure.[1,2] My own limited experience would show that when the indication of hematemesis is combined with that of melena, it constitutes the most common reason to perform EGD.

Were the cases done for GI bleeding excluded from the study? Did all the study participants refer these cases to subspecialty care, either due to the increased likelihood that therapeutic intervention would be needed or that they represented more "emergent" situations? Were these symptoms discounted because of their frequent association with those listed?