# 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 bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 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.**

### Management of Streptococcal Pharyngitis

*To the Editor:* The article "The Effects of the Rapid Strep Test on Physician Management of Streptococcal Pharyngitis"[1] has the admirable goal of studying actual practice. As family physicians "in the trenches," our most valued information is that which helps us care for our patients in real practice settings.

In that spirit, we should evaluate the rapid strep tests in light of our goal of treating patients with pharyngitis, rather than treating streptococcal pharyngitis. A test cries to be used, and the universe of tests available can easily define what diseases are considered.

The current rapid strep tests all suffer from the ability to detect only group A streptococcus. Other groups of streptococcus are pathogenic causes of pharyngitis, including group G[2] and group C.[3-5] Mycoplasmal and atypical organisms continue to be implicated as causes of sore throat.[6] The study by Corson, et al.[5] documents group C streptococcus as a more common cause of symptomatic pharyngitis than group A streptococcus.

My opinion is that the rapid strep tests have no place in day-to-day clinical practice. It is technically fascinating that the rapid strep tests work, but why use a test that identifies less than one-half of the treatable organisms? Those who persist in using the rapid strep tests should obtain a culture for patients with a negative rapid strep test.[7,8]

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### References

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### Cognition Dysfunction

*To the Editor*: While Rizzolo and colleagues have enumerated well the possible advantages of diagnosing dementia early through cognitive function screening, they have omitted some important potential disadvantages.[1] The mere labeling of a person as cognitively impaired risks creating barriers to health care beyond those that are strictly economic. Institutions and health care providers are often reluctant to manage the complex issues surrounding a dementing illness. Feeling the stigma of such a label, those so identified may avoid beneficial diagnostic evaluation and management. These are among concerns that place the value of this screening maneuver in doubt. In considering these issues, the Canadian Task Force on the Periodic Health Examination recently concluded that, "There is insufficient evidence to include routine screening for cognitive impairment in or exclude it from the periodic health examination of people over 65 years of age."[2]

Also, the authors have overstated the proven value of comprehensive geriatric assessment following a positive screening test for cognitive impairment. While some difficult cases identified in this manner may require a global assessment, these are not likely to be found at the local health fair. The benefit of geriatric evaluation has been reported in other limited contexts, not in the community-dwelling elderly and certainly not in those targeted simply because of cognitive impairment.[3]

Finally, by implying that interpretation of and follow-up after cognitive screening is primarily the realm of geriatricians, the authors ignore the capable and imperative role of community-based physicians in the diagnosis and management of dementing illness. While selected problems require the geriatrician's expertise, the very demographic factors they have mentioned will make referral more



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and more a luxury to be reserved for the more complex case.

Group cognitive screening may some day be a useful innovation, but major questions regarding its role and value remain unanswered.

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

*To the Editor*: Dr. Kirk has raised several concerns regarding potential disadvantages of screening for dementia. He states that the stigma of being labeled as cognitively impaired and the reluctance of institutions and health care providers to deal with dementing illness would place the value of screening in doubt. This concern is valid, and we did not suggest we launch, at this time, a mass screening campaign to detect early dementia. In fact, the first sentence in the discussion section states, "Significant practical, medical, ethical, and socioeconomic issues need careful consideration before launching any effort to identify community-based persons with cognitive impairment by the use of a group-administered screening instrument."[p 134]

Ethical use of any screening instrument requires the physician to inform the patient of the limitations and the benefits of the test, and adequate follow-up must be offered and available, including counseling to help the person deal with the "labeling" issue.

The Canadian Task Force, as quoted by Dr. Kirk, makes the common mistake of considering all persons more than 65 years of age as being in the same risk category. It is clear that the prevalence of dementia begins to rise sharply past the age of 70 years, and we suggest that cognitive screening of persons 75 years and older would identify significant numbers of impaired persons, many of whom would benefit from early detection.

We agree that many community, university, and hospital-based physicians without specific geriatric training are able to diagnose and manage persons with moderate or advanced dementia syndromes; however, patients with more subtle deficits would most likely require the expertise of physicians with specific geriatric experience and training.

If and when definite medical treatment for Alzheimer disease becomes available, it will be important to be able to identify persons with early disease, before extensive neuronal damage has occurred. Parallel to developing such treatments, we need to pursue efficient methods of identifying persons with early disease. Until such time as a reliable biologic marker is available, clinical evaluation of the patient's cognitive function may be our only option. It is reasonable and important, therefore, for researchers to pursue cost-effective, reliable, and easily administered instruments for the detection of early dementia.

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**Preemployment Evaluations**

*To the Editor*: We would like to commend Drs. Holleman and Matson for raising the important issue of preemployment evaluations by family physicians.[1] It is not surprising that there is a lack of practice standards among family physicians while performing preemployment evaluations.

The following are a few concerns of the practice environment that we believe should be identified as playing a role in preemployment evaluation dilemmas:

1. To match a person to the job properly, some testing may be necessary. For certain occupations, this testing may be mandated by law. One such example is the chest radiograph for those who are exposed to asbestos; another example is preemployment blood lead level measurement for those exposed to lead. Sometimes employers insist upon routine preemployment screening tests that may be of no value. Most tests not only are cost ineffective, but also present the liability and ethical issues of dealing with abnormal results.
2. On the confidentiality issue, most employers do not wish to know the test results, such as the cholesterol level. All they want to know is whether the applicant is fit to perform a prescribed job.
3. When performing a preemployment physical examination, the examining physicians should ask themselves whether this applicant can perform the prescribed job in the near future. Obviously, a person with lung cancer cannot perform even a clerical job because of the potential for frequent absenteeism from his illness. On the other hand, a person with a history of total knee reconstruction surgery may still perform a job of data entry without restrictions.
4. When performing a preemployment evaluation, physicians should limit themselves to the role of medical advisor to the employing agency. Physicians can make medical recommendations whether the applicant is fit to work. They should avoid making comments that may lead the appli-



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