In the referenced article by Spechler and Schimmel,[1] aortoenteric fistulae, a rare cause of obscure gastrointestinal bleeding, is discussed. The authors state that angiography was useful even in the absence of active bleeding. In those instances angiography might demonstrate a pseudoaneurysm at the site of the defect. In the individual who has undergone aortoiliac reconstructive surgery, who subsequently has gastrointestinal bleeding, angiography could be especially useful even in the absence of active bleeding.

We do not suggest not doing angiography in all individuals but do believe that in elderly frail individuals, one should consider empiric estrogen therapy rather than invasive diagnostic procedures.

Peter J. Rizzolo, MD
Warren P. Newton, MD
University of North Carolina
Chapel Hill

References

1. Spechler SJ, Schimmel EM. Gastrointestinal tract bleeding of unknown origin. Arch Intern Med 1982; 142:236-40.

Fracture Care

To the Editor: I read with interest the article entitled "Fracture Care by Family Physicians" by Eiff and Saultz in the March-April 1993 issue of *JABFP* (J Am Board Fam Pract 1993; 6:179-81). I would like to compliment the authors on providing some much needed and useful information in the area of fracture care by family physicians.

As noted by the authors, the study is limited by incomplete demographic information, but I would like to suggest a number of other concerns that I have about drawing too many conclusions from this study. Perhaps the authors can respond to some of these concerns.

First of all, I do not understand how to interpret Table 1, specifically the range of "days to healing" when they were as few as 5 days for a proximal phalangeal fracture. If the standard procedure of the clinic was to "see fracture patients every 10 days to 2 weeks to monitor healing and function," how could such a range be established? Further, the authors give us no indication as to the complication rate suffered by any of the 624 patients. Was there any occurrence of complications, such as ischemic contracture, failure to achieve full range of motion, tethering of tendons, or malrotation? The authors do state that once possible complications arose, the patient was referred to an orthopedic surgeon. Was this patient taken out of the study at that time or was the patient included in the study?

I would wholeheartedly agree that perhaps the recommended healing time as espoused by various orthopedic texts might be unnecessarily long. Another point concerns combination fractures such as Colles fractures. I see no category for that on either Table 1 or 2.

Finally, I would like to agree with the authors that "family physicians can care for a broad range of acute fractures with healing times at least comparable with the standard of care." Still, it would be wise to do not only a prospective study on this assumption, but to look also at outcome data in much greater detail.

Douglas B. McKeag, MD
Michigan State University
East Lansing

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

To the Editor: We are pleased that Dr. McKeag found information in our article useful, and we agree that the conclusions from our study are limited by retrospective design. We extracted information in the article from a fracture clinic log that recorded only numbers of visits and number of days to clinical healing. The purpose of the log was to document care, not to collect research data. Because of the dearth of information in the area of fracture care by family physicians, we thought it was important to report the information, however incomplete, because of the large volume of fracture experience within this one setting. The fracture clinic log used in this study did not collect information regarding complication rates or referral rates. We agree with Dr. McKeag that this information would be very useful for family physicians who need to know when to refer to a subspecialist. A prospective study of fracture care by family physicians including complication and referral rates would be most helpful for improving care to patients with fractures.

Dr. McKeag has raised questions regarding our reporting of the number of days to healing for the fractures listed. The log used to extract information for this study did not contain enough detail regarding the few outliers in the study that had very short healing times. In an active military population, some patients with minor nondisplaced fractures with minimal symptoms returned to their regular job very quickly and thus were discharged from the care of the fracture clinic.

We thank Dr. McKeag for raising these important areas of concern and hope that our brief report will stimulate others who care for many patients with fractures to consider doing a prospective study.

M. Patrice Eiff, MD
John W. Saultz, MD
Oregon Health Sciences University
Portland

AIDS Case Definition

To the Editor: Dr. Goldschmidt nicely summarized the new AIDS surveillance case definition and the potential problems that might be associated with the expanded criteria.[1] The article brought to mind another recent AIDS awareness program that could result in

J Am Board Fam Pract: first published as 10.3122/jabfm.6.4.436a on 1 July 1993. Downloaded from http://www.jabfm.org/ on 15 November 2026 by guest. Protected by copyright.