Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints might 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.

Recognition of Sexual Abuse

To the Editor: In her editorial "Recognition of Sexual Abuse,"[1] Dr. Hendricks-Matthews makes a statement that could have serious negative consequences for women who have been sexually abused. She states:

> Even family physicians who are highly experienced in counseling patients should not undertake counseling abuse victims unless they have specific training in this area. Referral to appropriately trained mental health professionals would be the proper next step in most situations.

She then states that "These resources exist in most communities . . . ." Although we do not disagree with referral to experts, we are aware that in the rural areas of our state there is often no mental health service of any kind.

The data on the availability of services are not clear. Even when mental health care is available, there are few mental health providers who are truly experienced in counseling sexual abuse victims. Thus, if physicians, already reluctant to deal with abuse, discover a patient who has been sexually abused and follow this advice, patients, who having revealed their pain and suffering, will suffer more by being left to their own resources in trying to heal the pain. We do not think Dr. Hendricks-Matthews intends this outcome, but considering how sensitive physicians can be to the danger of litigation that can occur if one does not follow "expert" opinions or guidelines, this advise might not be the best.

Also, having reviewed a great deal of the literature for our own abuse research, we have not read anything to support the above statement. Do we know what "ideal" counseling should be for these patients? Is no counseling better than imperfect counseling? Certainly, the principle of "do no harm" should be strongly considered if a physician wishes to counsel such patients, but perhaps a good listener can do much for these women. We should all work together to discover the key elements of the most effective counseling for abuse victims and not let them suffer in silence until we have the "perfect" counselors who are ready to help them.

Our own research and that of Walker, et al.[2] and others[3-5] indicate that there are great numbers of patients in primary care who need these services, and yet we doubt there are resources to handle all these patients adequately, even using mental health providers who are not expert in sexual abuse counseling. We need to encourage all primary care providers who believe they are competent in counseling skills to use them. As they open up the emotional wounds of these women, they must be open to referring them to those who are more skilled in sexual abuse counseling, if needed and if available. Until we have readily available services throughout the country, let us continue to help primary care providers recognize abuse by educating them about the prevalence and epidemiology of sexual abuse and then train them to provide counseling services, if they are so inclined. This, we believe, will be of greater benefit to abused women then to discourage the provision of such services by primary care providers until they are "experts."

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Obstetrics in Family Practice

To the Editor: Sakornbut and Dickinson[1] provided a service to our specialty by further confirming the importance of role models and hospital privileges in family practice residency training environments. On this issue of comprehensive women's health care, family practice residencies have been understaffed, underfunded, and politically manipulated by the amputation of hospital privileges.[2] As a member of the American Academy of Family Physicians (AAFP) Task Force on Obstetrics, 1989–1993, I believe the importance of maternal and fetal medicine to the overall welfare of our specialty cannot be over-

emphasized.[3] To provide support from the medical literature regarding the struggles faced by obstetrics-capable family physicians, the AAFP has compiled a bibliography that describes the data derived from the world's medical literature. This bibliography is available from the Huffington Library at the AAFP. These data can be helpful to family physicians seeking to provide objective information to hospital credential committees and others.

The recently published letter by Larimore[4] further documents the resurgence of obstetrics-enhanced family practice. I am pleased that some of my previous published material was cited. Reference 7 in the Sakornbut and Dickinson article was actually published in *Family Practice — An International Journal*.[5] This small typographic point should be noted for accuracy. Overall it does not detract from the contributions made by these authors and your journal in providing important data and support for family physicians who wish to deliver babies.

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Cholesterol Screening

To the Editor: Dr. Frame's recent article "Screening and Management of Cholesterol Levels in Children and Adolescents"[1] and the accompanying editorial by Dr. Grumbach[2] provide a refreshing dose of common sense on the issue of cholesterol screening. It is regrettable that the United States embarked on a mass screening policy before having demonstrated benefit to our people (as opposed to just our coronary arteries). Intervention studies have consistently failed to demonstrate overall benefit to study groups, and no benefit to the health of children or young adults (as opposed to change in laboratory values) has ever been shown. It seems that we have confused the observation that a lower cholesterol value correlates with less frequent coronary artery disease (well demonstrated) with proof that lowering cholesterol will lower incidence of coronary artery disease in the general population (only shown in groups with average cholesterol levels of 265 mg/dL or greater). Much of the medical profession seems to ignore the oft-repeated finding of no net benefit in morbidity and mortality in treated groups of otherwise healthy persons. How can family physicians justify cholesterol screening in the absence of evidence of its efficacy for most individuals?

Of course, there are groups, such as those with known coronary artery disease or with familial disorders of lipid metabolism, who benefit from aggressive cholesterol reduction. However, those benefits are achieved with step 2 diets and medication intervention. Only these interventions (and surgical removal of parts of the bowel) have been shown to lower both coronary and overall morbidity and mortality, and then only in those with known coronary artery disease.

The issue of cholesterol screening in all populations is germane as we debate new financing schemes for health care in America. Here is one instance where we could learn from those with a national health system. The Canadians and British have both concluded that screening for and treating values of serum cholesterol below 265 mg/dL are just not worth it.

Family physicians are oriented to preventing as well as treating disease. The possibility of reducing risks for our patients, so successfully achieved through national initiatives on smoking cessation and hypertension, has, I submit, lured us into adopting a cholesterol-lowering national campaign without evidence that it could (let alone would) work. It is time for us to step back, reassess the data, and consider whether the effort and resources involved in this campaign could not be better spent on other strategies to improve our patients' and the nation's health.

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Treatment of Black Widow Spider Bite

To the Editor: The treatment described in Zukowski's report of 2 patients with black widow spider envenomation[1] typifies what I believe to be common misconceptions about the therapy for black widow envenomation — the overreliance on calcium therapy and the underutilization of specific antivenin.

The role of calcium in the diagnosis and treatment of black widow spider envenomation has evolved largely from anecdotal experience. No controlled study has been performed to determine optimal treatment. While a dramatic response to calcium is seen in some patients, failure to respond does not exclude the diagnosis. In one of the few prospective studies on the subject, Key[2] found calcium effective in only 6 of 13 patients. Only 1 of 6 patients with the most