

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.

Transdermal Nicotine Patches

To the Editor: In the September-October 1994 issue of *JABFP*, Montalto, et al. describe a possible suicide attempt by a 15-year-old girl who placed 14 transdermal nicotine patches on her body.¹ Your readers might be interested in a fictional murder attempt using the patches described in *Thank You For Smoking* by Christopher Buckley.² Nick Naylor, the chief spokesman for the Academy of Tobacco Studies, is kidnapped and covered completely with nicotine patches. He survives the resulting paroxysmal atrial tachycardia, nausea, vomiting, skin rash, blurred vision, neuralgia, and cold numb extremities. Nick concludes that smoking saved his life, and that the nicotine patches are killers. But he can no longer tolerate cigarettes — a major liability in his job. All ends well, however, with Nick working for Clean Lungs 2000, an organization that tries to get people to stop smoking. I highly recommend reading the book (after finishing the current issue of *JABFP*, of course)!

Diane J. Madlon-Kay, MD
St. Paul, MN

References

1. Montalto N, Brackett CC, Sobol T. Use of transdermal nicotine systems in a possible suicide attempt. *J Am Board Fam Pract* 1994; 7:417-20.
2. Buckley C. *Thank you for smoking*. New York: Random House, 1994.

Open-ended Vasectomy

To the Editor: As Denniston and Kuehl¹ reported in their article, and affirming previous reports, the open-ended vasectomy technique has "low complication and failure rates." The open-ended technique implies that no occlusive procedure (cautery or ligation) is performed to the testicular end of the divided vas deferens.

Having performed approximately 200 vasectomies and reviewed the literature, I would suggest that what has been presented as the open-ended vasectomy is more accurately the semi-open-ended vasectomy, as only one of the two ends of the divided vas deferens is left open. The technique I use is a modification of the one described by Schmidt² but with no occlusion of either end of the vas. To the best of my knowledge there have been no failures, and no patient-initiated

return visits for complications — hematomas, granulomas, or infections.

As much as Denniston and Kuehl and their predecessors have shown improved outcome by not occluding the testicular end of the vas, I am unaware of any substantive evidence supporting the occlusion of the prostatic end of the vas.

My experience suggests a comparable (positive) outcome from performing no occlusive procedure on either end of a divided vas deferens. That same experience and review of the literature strongly suggests that the keys to successful vasectomies (low or no failures or complications) are being familiar and comfortable with the technique, meticulous attention to basic fundamentals (i.e., hemostasis), and the interposition of a fascial sheath between the divided ends of the vas.

If the semi-open-ended vasectomy approaches the ideal vasectomy, a truly (both ends) open-ended technique might even more closely approach the ideal. Such practice-based research is well-suited to and, as demonstrated by Denniston and Kuehl, can be done well by family physicians.

Daniel J. David, MD
Johnson City, TN

References

1. Denniston GC, Kuehl L. Open-ended vasectomy: approaching the ideal technique. *J Am Board Fam Pract* 1994; 7:285-7.
2. Schmidt SS. Techniques and complications of elective vasectomy. *Fertil Steril* 1966; 17:467-82.

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

To the Editor: Dr. David's letter and comments concerning open-ended vasectomy are appreciated. The rationale for closing the prostatic end of the cut vas is to prevent failures. Cauterizing and covering it should increase the probability that failure will not occur. On the rare occasions when the interposed barrier fails, the cauterized vas prevents recanalization and thus unwanted pregnancy. Even if Dr. David's series went to 4000 cases with careful follow-up and with no failures, these results would only testify to his skill in consistently interposing a barrier. A truly open-ended technique should not be as effective as our method in preventing failures in other hands.

George Denniston, MD
Laurel Kuehl
Seattle, WA

Communication in Consultation Process

To the Editor: Scott & White is a large multispecialty group of 429 physicians and 205 residents, including 66 family physicians at 11 regional clinic sites, associated with a 100,000-member health maintenance organization and a 400-bed hospital. Because of our own