As the scholarly publication of the osteopathic medical profession, JAOA—The Journal of the American Osteopathic Association encourages osteopathic physicians, faculty members at osteopathic medical colleges, students, and others—as consistent with the mission of the JAOA—to submit their comments to the JAOA.

Letters to the editor are considered for publication if they have not been published elsewhere and are not simultaneously under consideration by any other publication. All accepted letters to the editor are subject to copyediting. On request, the corresponding author is responsible for providing the editor with photocopies of referenced material.

When sent by mail or fax, letters must be typewritten and double-spaced. Except in rare instances, the text of a letter should not exceed 500 words and should not include any more than five references and two tables or illustrations. JAOA encourages its readers to submit letters electronically to jaoa@ostopathic.org.

Letter writers must include their full professional title(s) and affiliation(s), complete address, day and evening telephone numbers, fax number(s), and e-mail address(es). Letter writers are responsible for disclosing financial associations or other possible conflicts of interest.

Although JAOA cannot acknowledge the receipt of your letter, we will notify you if the letter has been accepted for publication. Rejected letters and illustrations will not be returned unless accompanied by a self-addressed stamped envelope.

Address letters to Gilbert E. D’Alonzo, Jr, DO, Editor in Chief, JAOA, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611-2864. Fax: (312) 202-8200. E-mail: jaoa@ostopathic.org.

---

Subgroup Demographic May Have Skewed ALLHAT Results

To the Editor:

Results of the recent Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) have generated much excitement and controversy. The reported superior performance of thiazide diuretics brought the trial under scrutiny for reasons that include experimental design, population characteristics, primary and secondary endpoints, and statistical analysis.2,3 We propose an alternative explanation for the drug’s superior performance based on the new field of pharmacogenetics. The drug’s result may be a function of the genetic predisposition of the study’s subjects.

It has been shown that more than 76% of African American men have the C825T polymorphism, a predisposition that confers a superior response to thiazides.1 As 35% of the subjects in the ALLHAT study were African American, the influence of this polymorphism could have skewed the results. Responses to angiotensin-converting enzyme inhibitor or calcium channel blocker vs diuretic: The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). JAMA. 2002;288:2981-2997.

References


Strength in Collaboration

To the Editor:

I found the article by Peter R. Przekop, Jr, DO, PhD, et al (Am J Osteopath Assoc. 2003;103:543-549) to be extremely encouraging and representative of the direction I hope osteopathic graduate medical education is headed on a national scale. Having graduated from Des Moines University, College of Osteopathic Medicine in 2001, I am completing a 5-year residency in pathology at a university-based allopathic medical center. Although I have little opportunity to use osteopathic manipulative medicine in the field of pathology, I am proud of my osteopathic medical heritage and am versed in both osteopathic medicine’s philosophy and history.

The osteopathic medical profession has experienced tremendous growth and acceptance over the past 30 to 40 years. I believe that this is due in part to collaborative efforts between osteopathic physicians and our allopathic colleagues, particularly in graduate medical education. For a variety of reasons, some of which are addressed in Dr Przekop’s article, more and more osteopathic medical school graduates are completing residency training in allopathic medical centers. (There were few alternatives in my situation, given the lack of osteopathic medical programs in the field of pathology.)

The acceptance and integration of osteopathic physicians into allopathic medical institutions has allowed an opportunity to introduce osteopathic principles and practice to allopathic physicians and medical school students. What I hope will occur is a
Let’s Learn From the Influenza Epidemic

To the Editor:
In the editorial by M. Reza Nassiri, DSc, about severe acute respiratory syndrome (SARS), “Severe Acute Respiratory Syndrome Deserves Scientists’ and Physicians’ Full Attention” (J Am Osteopath Assoc. 2003; 103:359-360), the author states that there is no treatment available for the condition.

This is the same statement made by medical leaders about the 1918 influenza epidemic; however, there is much documented information to indicate that the use of osteopathic manipulative treatment (OMT) resulted in far better survival of patients than other medical approaches.

It would seem that OMT should also be efficacious in SARS as suggested in “DOs Ponder Parallels of Flu and SARS Battles” (The DO. 2003;44:34-36), and it is of significance that the United Christian Hospital in Hong Kong has reported that young children who have SARS have fewer and milder symptoms and recover faster than adults. This was also noted in the 1918 flu epidemic when the mortality rate was highest in healthy adults between 20 and 40 years of age.

If the current outbreak of SARS is similar to the 1918 influenza, OMT may be the only effective therapy. In any event, it is worth a trial.

Martyn E. Richardson, DO
Scarborough, Maine

References

Response

Dr Richardson seems to be concerned about my statement that no treatment is available for patients with severe acute respiratory syndrome (SARS). It is clear that I was referring to pharmacologic treatment. If, as Dr Richardson claims, osteopathic manipulative treatment (OMT) “should also be efficacious in SARS” (a vague statement), then why have osteopathic physicians not (to the best of my knowledge, as I routinely check SARS literature) informed the World Health Organization and the Centers for Disease Control and Prevention of such a revelation? Second, why are there no peer-reviewed data regarding use of OMT in treating patients with SARS found in medical journals?

In the same letter, Dr Richardson states that “...it is worth a trial,” acknowledging that OMT has not been used in patients with SARS, yet, he also claims there is an OMT technique for SARS. If Dr Richardson is suggesting that patients with SARS would benefit from OMT, I am happy to acknowledge such a statement, as I believe most patients with respiratory symptoms would benefit from OMT. However, the question remains: Has OMT been recently used for patients with SARS? I am afraid not.

M. Reza Nassiri, DSc
Professor of Medical Virology
Lake Erie College of Osteopathic Medicine
Erie, Pennsylvania

Erratum

JAOA—The Journal of the American Osteopathic Association regrets the following errors:


In Table 2, the number of applications for Midwestern University’s Chicago College of Osteopathic Medicine (CCOM) and Des Moines University College of Osteopathic Medicine and Surgery (DMU/COMS) for the 2002-2003 academic year were reversed. For number of applicants, CCOM should reflect 2452; DMU/COMS should reflect 2070. In addition, first-year enrollment for the same period for CCOM should be 172; for DMU/COMS, it should be 216. Finally, the total enrollment at CCOM for this period should be listed as 643 and DMU/COMS should be listed as 802.