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Letters to the editor are considered for publication in the JAOA with the understanding that they have not been published elsewhere and that they are not simultaneously under consideration by any other publication.

All accepted letters to the editor are subject to editing and abridgement. Letter writers may be asked to provide JAOA staff with photocopies of referenced material so that the references themselves and statements cited may be verified.

Readers are encouraged to prepare letters electronically in Microsoft Word (.doc) or in plain (.txt) or rich text (.rtf) format. The JAOA prefers that readers e-mail letters to jaoa@osteopathic.org. Mailed letters should be addressed to Gilbert E. D’Alonzo, Jr, DO, Editor in Chief, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611-2864.

Letter writers must include their full professional titles and affiliations, complete preferred mailing address, day and evening telephone numbers, fax numbers, and e-mail address. In addition, writers are responsible for disclosing financial associations and other conflicts of interest.

Although the JAOA cannot acknowledge the receipt of letters, a JAOA staff member will notify writers whose letters have been accepted for publication. Mailed submissions and supporting materials will not be returned unless letter writers provide self-addressed, stamped envelopes with their submissions.

All osteopathic physicians who have letters published in the JAOA receive continuing medical education (CME) credit for their contributions. Writers of original letters receive 5 hours of AOA Category 1-B CME credit. Authors of published articles who respond to letters about their research receive 3 hours of Category 1-B CME credit for their responses.

Although the JAOA welcomes letters to the editor, readers should be aware that these contributions have a lower publication priority than other submissions. As a consequence, letters are published only when space allows.

**Elderly Patient With Small Bowel Volvulus**

*To the Editor:*

A 90-year-old man came to our emergency department complaining of a 3-day history of progressively worsening abdominal pain. He reported that prior to the occurrence of abdominal pain, he had one loose bowel movement—but no loose bowel movements since. He denied any nausea or vomiting. Physical examination revealed the patient to be slightly distended and mildly tender to palpation at the periumbilical region. His medical history was significant only for an inguinal hernia repair, and he had no other abdominal operations.

The hospital’s general surgery team was consulted. A computed tomography (CT) scan was ordered, and results were reviewed with radiology staff. The CT scan demonstrated dilated loops of small bowel but no clear cause of obstruction.

Because the patient was not improving clinically the day after the CT scan results, he was taken to the operating room for an exploratory laparotomy. Dilated loops of small bowel were found, with a transition to decompressed small bowel at the mid-ileum level. Close examination showed the dilated small bowel to be twisted at its mesenteric root, forming a small bowel volvulus (SBV). Surgeons (including M.D.D.) untwisted the volvulus and decompressed the dilated loops of bowel. Evaluation of the remaining small bowel showed no other obstructions and no intraabdominal adhesions. The abdomen was closed, and the patient was moved to the recovery room in stable condition.

An extensive review of the literature (using MEDLINE, PubMed, and Google) indicated that when a patient has no history of abdominal surgery and is obstructed, SBV is not a common etiologic factor for the obstruction.1,2 When an SBV is present in elderly individuals, it is typically caused by intraabdominal adhesions. This form of SBV, called secondary SBV, generally occurs in patients aged in their 60s to 80s. Because the patient in our case had no history of abdominal surgery, his SBV is classified as primary SBV, a type of volvulus for which no clear anatomic etiologic factor can be found.1

Primary SBV is more common in children and young adults than in elderly individuals. The mechanism of primary SBV has been correlated with the ingestion of a large amount of fiber-rich foods in a short time.3,4 The subsequent forceful small bowel peristalsis is believed to be the cause of the primary SBV.

Countries with fiber-rich diets have a 10-fold increase in the occurrence of primary SBV, compared to countries with less fiber in their diets.3,4 Although rare in Western countries, SBV has been noted in cultures in which people ingest large amounts of fiber-rich foods, such as during festivals or after prolonged fasts. Such cultures originate in parts of Africa and the Middle East.1,3

Certain anatomic variations have been proposed as etiologic factors for SBV. For example, some researchers have asked whether either a short or long mesenteric root may be associated with primary SBV.1,2 Frazee et al proposed that a long...
mesenteric length and short mesenteric base are linked to SBV. In addition, changes in gut motility have been noted as a cause of primary SBV. In Uganda, for example, primary SBV has occurred in individuals after consumption of local beer containing gut motility stimulant.

In areas with widespread parasitic infections, close correlation has been made among these infections, changes in small bowel motility, and primary SBV.

Diagnosis of SBV can be made with a CT scan of the abdomen and pelvis. The CT images typically show a whirl-like pattern of mesentery, which is caused by the small bowel rotating around the mesenteric axis. This whirl-like pattern was not clearly demonstrated in the CT scan of our patient. Because this pattern was not seen, the presence of an SBV was not expected to be found during this patient’s exploratory laparotomy.

Our extensive literature search did not indicate that primary SBV is a common etiologic factor in elderly patients with no history of abdominal surgery. We have written this letter to counter the lack of literature information on this topic and to inform readers of JAOA—The Journal of the American Osteopathic Association to keep primary SBV in mind as a possible cause of obstruction when no clear etiologic mechanism is demonstrated by radiologic examination.

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References

Medical Business Education in Colleges of Osteopathic Medicine

To the Editor:
Regarding the disagreement that Debra A. Smith, DO, expresses with my suggestion that osteopathic medical students could receive adequate instruction in medical business topics in 5 to 10 hours, I wish to point out that the premise of such instruction should not be to create more “administrative suits” out of physicians by running them through MBA-level programs in medical economics and healthcare modeling paradigms. Given that osteopathic medical students today receive no formal education in medical business and that individuals in charge of curriculum development at colleges of osteopathic medicine seem to struggle intensely with medical education planning based on limited hours, 5 to 10 hours of business-focused education would be an enormous amount of time for the average student to learn many essential aspects of medical business that they currently must acquire ad hoc.

Dr Smith would also likely disagree with my perspective that we do not need more complexity added to medicine. Medical economics become absurdly simple when actual market models are applied to the system. This nation successfully used fee-for-service in primary care for almost all of its history until comprehensive medical insurance became a widespread product. The last things we need are more layers of bureaucracy and cost added to the system by expecting that the only people qualified to comment intelligently on the economics of medicine must be graduates of the osteopathic equivalent of the Wharton School of business. Of the five self-made millionaires who are close friends of mine, only one graduated from college. Yet, all of them currently run very successful businesses that employ hundreds of people. The concepts of business are quite simple if one understands the basics and has the requisite discipline to apply them.

The predominant problem that we confront today is that these “comprehensive” insurance products have created a false and unnecessarily complex system that cannot accurately predict the needs of patients as consumers or the number of physicians that are required in the US market. By contrast, if people paid the full cost of primary care, I suspect that we would see far fewer individuals showing up in the office “just to get checked out.” As a result, demand for services would necessarily drop, and the need for physicians would shrink.

The bottom line is that right now—lacking any sort of basic understanding of medical business—osteopathic medical students would derive tremendous benefit from 1 hour per week of business education in a quarter of their sophomore year. At the very least, such education would illustrate the utter disconnect between the producers and consumers of the medical economy. I would hope that it would also spur our emerging young osteopathic physicians into action to demand, both professionally and politically, that their profession and means of reimbursement be placed back in their hands, rather than the hands of business school graduates.

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References