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Letters to the editor are considered for publication in 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 copyediting. 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 letters be e-mailed to jaoa@osteopathic.org. Mailed letters should also be sent electronically, in one of the aforementioned electronic formats on an IBM-compatible CD or a 3-1/2-inch disk, and 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 addresses, day and evening telephone numbers, fax numbers, and preferred e-mail addresses. Authors are responsible for disclosing financial associations and other conflicts of interest.

Although 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 authors provide self-addressed, stamped envelopes with their submissions.

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Report of Case: Relapse of Condyloma Acuminatum and Mistrust of Physicians in Homeless Patient

To the Editor:

In March 2004, a 40-year-old homeless male reported to our clinic complaining of a large, painful mass growing posterior to his scrotum. The patient rated the severity of the pain as an 8 on an ascending scale with 10 as the most severe. He noted that the pain was worse when he sat on cold concrete, and that walking provoked additional pain. His pain while sitting was so unbearable that it interfered with his ability to operate a forklift, resulting in the subsequent loss of his job.

Upon physical examination, a fungating mass measuring 4 cm by 7 cm, consistent with condyloma acuminatum, was noted posterior and to the left of the scrotum (Figure). The mass was ulcerated and bleeding. The patient stated that the bleeding occurred daily and required that he dispose of his undergarments every 1 to 2 days.

A focused history of the patient revealed a case of a similar-sized lesion that was noted in 1992 on the posterior right side of the scrotum. The patient was treated for this lesion in 1996 with cryotherapy and carbon dioxide laser ablation. However, the condition was complicated by a subsequent infection of the surgical wound, resulting in the reappearance of a small lesion within a few weeks of surgery. In 1998, there was an unsuccessful attempt to eliminate the lesion with acid treatment. Subsequent to that treatment, the lesion continued to grow.

Approximately five weeks before the patient arrived at our clinic, the condyloma acuminatum began to ulcerate and tear, leading to a rapid growth of the lesion. According to the patient, the lesion grew by some 50% during that period.

The patient’s past medical history was significant for alcoholism, but the physical examination at the clinic was otherwise within normal limits. The patient was referred to a local hospital for treatment. However, as is the case with many of the homeless patients who are treated at our clinic, follow-up care was not performed because the patient moved and could not be located again.

Condyloma acuminata are usually cauliflowerlike masses found on the urethra, penis, female genitalia, perianal area, or rectum.1 The lesions are typically limited to a few centimeters in diameter at the time of presentation to physicians. Human papillomavirus type 6 and type 11 are responsible for most cases of condyloma acuminatum,1 which affects slightly more than 1% of the adult population.2 The peak incidence occurs in individuals who are between 20 and 24 years old, with a peak prevalence in individuals 17 to 33 years old.3 The differential diagnoses for such large, bleeding masses include Bowenoid papulosis, Buschke-Löwenstein tumor, condyloma latum, and squamous cell carcinoma.1

Surgical treatment options include...
cure with this treatment modality is 70% of patients, the rate of long-term cure with this treatment modality is only 60%, at best.5

Patients need to be educated about the risk of relapse. The patient in this case was not informed of the low rate of remaining asymptomatic after surgery. When the condyloma acuminatum returned, the patient developed a distrust of physicians—a distrust that contributed to his refusal to seek treatment until the lesion grew quite large. Proper education from his physician might have encouraged the patient to seek treatment sooner, making it unlikely that he would have lost his job.


catarization, laser ablation, and surgical excision.4 However, only 36% of patients remain free of condyloma acuminatum three months after surgery.4 Pharmacologic treatment usually involves topical therapy with imiquimod or podophyllin.4,5 Although pharmacologic treatment is effective for 70% of patients, the rate of long-term cure with this treatment modality is only 60%, at best.5

Figure. Condyloma acuminatum lesion posterior and to the left of patient’s scrotum.

Patients need to be educated about the risk of relapse. The patient in this case was not informed of the low rate of remaining asymptomatic after surgery. When the condyloma acuminatum returned, the patient developed a distrust of physicians—a distrust that contributed to his refusal to seek treatment until the lesion grew quite large. Proper education from his physician might have encouraged the patient to seek treatment sooner, making it unlikely that he would have lost his job.

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References

Doctors’ Dilemma: Prescription Pain Medications

To the Editor:

A patient came to me with the following complaints: a tragic wound obtained in Iraq, terrible pain, nightmares induced by posttraumatic stress disorder (PTSD), and a lack of compassion and care on the part of the United States Army. Moved by my patient’s plight, I agreed to adjust his pain medication to a higher dosage, and I gave him contact information for a colleague in his area who had connections with groups that offer counseling for people with PTSD. As a veteran myself who served in Iraq for a year, I hugged the patient and told him that we would help him as fellow brothers. I left the office feeling pretty good about the part of the United States Army. The second is the high number of patients I see who are being prescribed serious narcotics for relatively minor problems. Very few of these patients are enrolled in formal pain-management programs, and those that are, it is relatively easy for them to find physicians who will fill additional prescriptions without the knowledge of their pain specialists.

Physicians are in a terrible quandary. If a patient is “doctor shopping”—that is, seeking care from multiple physicians for the purpose of obtaining multiple prescriptions for controlled substances—and if the physician is aware of it, the physician is in knowledge of a felony. As such, the physician is obligated to report it. However, as soon as the crime is reported, the physician faces a great deal of time in court as a witness, as well as the ire of his colleagues who also find themselves in court because of their unwitting participation in a drug seeker’s efforts to illegally obtain and use narcotics. Failing to report a felony is a crime that could get physicians relieved of their licenses and subject them to criminal penalties.3
Physicians also face the dilemma of wanting to help legitimate pain sufferers without having the ability to determine who is lying and who is telling the truth about their pain. I have found myself having to explain my “harsher” approach to patients who wonder why, after years of using acetaminophen/oxycodeone (Percocet), they now must see pain-management specialists. I tell them that, as in junior high school, a few misbehaving individuals cause everyone to pay a price. I no longer prescribe any scheduled or controlled medications without a demonstrable fracture or history of cancer, unless I first consult a pain-management expert.

There are many nonnarcotic options available for patients, but the protests are legion when I suggest them. I have been verbally assaulted by a patient in the emergency department for not prescribing a narcotic to that individual, who had failed to keep a pain-management referral and who had been seen at several other emergency departments. I have also been confronted by a patient who I initially thought had legitimate pain complaints but whose subsequent urinalysis indicated the presence of tetrahydrocannabinol, the active compound in marijuana, but not the presence of opiates—despite the fact that the patient had been using oxycodone hydrochloride (OxyContin) for years under the care of another physician. He tried to explain these findings by pleading, “You understand, doc, I just smoked some pot. Come on, doc. It was just pot!”

I replied, “No, I do not understand. I spent a year away from my wife and kids, lost three friends between Iraq and Afghanistan, and had a young man I have known since he was a baby lose his leg to an IED [improvised explosive device]. I am drug tested yearly, and I have never used drugs. No, frankly I do not understand. By the way, where is your OxyContin going if it isn’t in your urine?”

Examples such as this kind can further jade a physician against future prescribing, even in the face of seemingly legitimate pain.

The United States has poured billions of dollars into an international “drug war,” while it has virtually ignored the fight at home. Every day in this country, drug dealers, users, and traffickers show up in physicians’ offices, playing against physicians’ sympathies and our legal mandate to address patient pain in a timely and appropriate manner. These criminals take their prescription medications (many of which are paid for by state Medicaid programs for the poor) and walk out to sell them for cash, as some of my own patients have admitted to me. The only difference between these cases and instances in which the Medellin drug cartel pumps our kids full of cocaine is that the former cases are conducted under the guise of medical legitimacy.

Data for retail and mail-order pharmaceuticals reveal that acetaminophen/hydrocodeone (Vicodin), which is a narcotic pain reliever, is now the number-one prescribed drug in the United States, with atorvastatin calcium (Lipitor), a medication used to lower elevated cholesterol levels, running second. In my area of the country, Vicodin sells for about $10 a tablet on the street, according to some of my patients.

The most serious problems occur when addicts show up at clinics and demand specific drugs under threat of harm to nurses or physicians. Such threats have happened to some of my colleagues. I did not spend the better part of my youth in school to face threats from drug addicts. It is truly enough to cause a person—and it has caused me—to start looking at other ways of making a living.

There is a solution to this problem, but like many solutions, the implementation of it after years of neglect will not be easy or pleasant. I offer the following four suggestions.

First, the federal government must mandate that computer systems link all pharmacies that dispense controlled substances. When a patient solicits the same medication from several different pharmacies, the pharmacist is immediately alerted as soon as the prescription information is entered. Pharmacists should then be required to report this data to law enforcement authorities.

The federal government should also mandate—just as it has with HIPAA—that practitioners who prescribe controlled substances comply with a federal standard for tracking the use and effectiveness of those substances. These records should be clear and comprehensive so that when the Drug Enforcement Administration needs to investigate alleged abuse, it can readily form a paper trail to prosecute drug abusers.

In addition, federal programs such as Medicaid and Medicare must mandate that each recipient of federal assistance for medical care has an assigned family physician. I know from personal experience that many patients seen in emergency departments have no family physician. Therefore, it is fairly easy for them to go from one emergency department to the next, collecting drugs without being caught. Currently, there is little or no surveillance of Medicaid patients using emergency departments as their sole source of medical care. I have seen certain Medicaid patients use the emergency department as many as 23 times in one month for minor health problems, and nobody from social services ever called to inquire why. This is not only terribly abusive of the taxpayers, whose money is used to help people in need, but it is a huge drain on federal resources that are needed to care for the truly needy and the growing elderly population.

Finally, the pharmaceutical companies that manufacture medications for chronic pain must be challenged to produce more medications like morphine sulfate (Avinza), which is a time-
released opiate sold in capsule form. Avinza is excellent for severe pain but produces no “rush” or euphoria like OxyContin tablets; therefore, it has no street value. By contrast, the current street value of OxyContin is about $1 per milligram, and a prescription for OxyContin (40 mg) taken twice daily for a month is worth $2400. In general, capsule medications are less valuable than tablet medications, because tablets are easier to divide, “cut,” or otherwise tamper with than capsules, leading potential buyers to have doubts about the drug’s safety and efficacy.

I believe that the abuse of prescription medications by patients has reached the level of a national crisis, resulting in wrecked lives, neglected children, violent crime, injured police officers, and deaths of addicts. This crisis also affects every patient in the country—as one of my own patients found out recently, when after years of caring for her for arthritis, I told her I now had to refer her to a pain-management expert. I explained, “I do not have a pain meter in my head, and I can’t tell who is or is not telling me the truth [about their need for pain medication].”

The longer the United States delays in establishing strict criteria and digital monitoring of the use of pain medications, the more likely it is that the average person in need of such medication for pain control will be confronted by physicians who refuse to prescribe without a consultation. This situation does not help patients in need of care and it causes grief for those of us who have made the care of the suffering our profession.

However, there is one alternative. It is terribly unpleasant, but if the United States refuses to treat the drug problem as a true national crisis, then the only option, in my opinion, is the full legalization of narcotics. I have struggled with this conclusion, but I believe that making these drugs legal would lower their value through market pressures, removing the financial incentive for the people involved in making and moving these substances. I shudder at this thought, but it is the sad truth and one that, after serving my country in Iraq, I wish I did not have to return home to.

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Dynamic Duo: Maine-Dartmouth Family Practice Residency Program and University of New England College of Osteopathic Medicine

To the Editor:
This letter is written to describe the increasing collaboration between the Maine-Dartmouth Family Practice Residency (MDFPR), which is Maine’s oldest family practice residency program,1 and the University of New England College of Osteopathic Medicine (UNECOM), which is Maine’s only medical school.2 It is written from my perspective as an osteopathic physician (DO) who practiced for 20 years in rural Maine and who now serves as a medical educator.

The Maine-Dartmouth Family Practice Residency program began as a joint project involving community hospitals in the Kennebec Valley region, the Veterans’ Administration Hospital of Togus, Me; and Medical Care Development Inc, a rural research and development organization headquartered in Augusta, Me.3,4 The MDFPR program was first accredited in 1973 as the allopathic Central Maine Family Practice Residency program.4 In 1979, the program became affiliated with Dartmouth Medical School in Hanover, NH, and, in 1980, it became incorporated as the MDFPR.4

In 1994, the MDFPR directors signed a second medical school affiliation agreement, with UNECOM in Biddeford, Me.4 This agreement established a traditional rotating osteopathic internship. In 2005, the American Osteopathic Association (AOA) accredited the MDFPR with an additional two-year osteopathic family practice residency.5 A 1998 article in Family Medicine by Johnson et al6 described the process by which allopathic residency programs, such as the MDFPR program, complete the AOA accreditation process to become approved osteopathic internship sites.

The MDFPR program expanded from six graduates per year to nine during the early 1990s,4 when a second model practice was added in Fairfield, Me—20 miles north of our Augusta practice—near the Waterville campus of Mid-Maine Medical Center (now MaineGeneral Medical Center).4 The program has always enjoyed a strong reputation, which was bolstered by John McPhee’s three-part series, titled “Heirs of General Practice,”7 that appeared in The New Yorker in 1984. McPhee described the daily work of a number of family practice residents in the MDFPR program.

More than 200 family physicians have graduated from the MDFPR program, and over 60% of these graduates have stayed to practice medicine in Maine, many in small rural practices.8 In a national report released in March 2005 on physician placement for the
1997–2003 academic years, the MDFPR program was ranked as the medical residency program with the greatest number of graduates opening practices in rural areas in the United States.9

Third- and fourth-year medical students at UNECOM began outpatient family practice clerkships in the MDFPR program in 1994. The University of New England College of Osteopathic Medicine has been eager to find more rotation sites in Maine. In August 2004, four third-year UNECOM students began their core rotations in psychiatry, surgery, internal medicine, and family medicine. In August 2005, seven third-year students began their core rotations, which included rotations in obstetrics and pediatrics, at various sites in the network of MaineGeneral Health.

The UNECOM students in the MDFPR program attend morning signout, in which they begin to learn the regular routine of the house medical staff. In the family medicine rotation, students see their own patients, with one-on-one precepting by a provider. In the internal medicine rotation, students participate as team members, with each student receiving increasing responsibilities as he or she progresses through the program.

One afternoon each week in the MDFPR program is set aside for educational sessions on medical ethics, pain management, sports medicine, or other medical topics. Two hours of each session are devoted to hands-on training in the use of osteopathic manipulative treatment. Students also participate in late afternoon informal conferences, in which residents present unusual or difficult cases from their practice experiences.

As an intern in 1974, I was accepted into the pre-Dartmouth Maine Family Practice Residency program, so I could have been in one of the program’s earliest graduating classes. However, I chose to become one of two family practice residents at the former Osteopathic Hospital of Maine in Portland (now the Maine Medical Center–Brighton Campus). Later, I became the codirector of that hospital’s residency program for many years. Thus, it seems ironic to me that I ended up back at the MDFPR program.

I have been associated with UNECOM since its inception, and I have volunteered many hours of precepting and teaching. Now, I am asking my former students, many of whom have established practices in the area, to contribute to the education of the next generation of UNECOM students. This step would help continue the tradition that has led to the impressive growth of the osteopathic medical profession in Maine and throughout New England (S. Strout, oral communication, October 2005). The MDFPR program’s first-year residency class for the academic year 2005–2006 includes seven DOs, all of whom are UNECOM graduates.

We are orienting both the residents and medical students in the MDFPR program on teaching and learning skills so that the educational process can be refined. The residents and medical students are offered opportunities to keep learning new portfolios throughout their years of clinical training. Documentation produced in the program for each resident and student includes information on his or her strengths and weaknesses, education goals, and critical events, as well as reflections on that individual’s practice experience.

The MDFPR program has shown itself to be a family practice residency program in which DOs and allopathic physicians respect each other and work together in a collegial manner.

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Letter to the Editor:

I am responding to the letters by Bryan E. Bledsoe, DO, and John C. Licciardone, DO, in the October 2004 issue of JA—The Journal of the American Osteopathic Association (“The Elephant in the Room: Does OMT Have Proved Benefit?” Available at: http://www.jaoa.org/cgi/content/ full/104/10/405). The response of Dr Licciardone to Dr Bledsoe’s harsh comments about osteopathic manipulative treatment (OMT) was gentle, subdued, and proper, I suppose, because there is much controversy surrounding this topic. However, I do not know why one

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would say that OMT needs further research to prove its efficacy.

My family became acquainted with osteopathic medicine in about 1913, when my maternal grandmother became very ill from some type of gastric disturbance. There were three allopathic physicians (MDs) in our hometown of Jackson, Minn, and each came to examine her. All three of these physicians told the family that nothing could be done and that my grandmother was going to die.

At about that same time, two young osteopathic physicians (DOs) moved into Jackson and, since the best MDs around had given up on my grandmother, the family decided to try osteopathic medicine. The DOs were Drs Dymond and Calhoun. Dr Calhoun left Jackson after two years, but Dr Dymond stayed in town until his death at about 90 years of age. Dr Calhoun came morning and evening in his horse and buggy to treat my grandmother. Within a week, she was up and well and doing her work again. For me, this was a most impressive introduction to osteopathic medicine.

Now, the reader and I both know that the restoration of my grandmother’s health could have been a coincidence, but my family firmly believed that OMT saved her life.

I think my most important early experience with osteopathic medicine began one rainy day when Elmer Johnson and I were having a friendly scuffle, and he put me in a headlock. When I tried to get out of the headlock, I twisted my neck. Within two seconds, I was suffering from acute nausea. After I shouted at Elmer and he let me go, my nausea subsided somewhat, but it did not go away. Now and then for weeks afterward, I had nausea to the point where it seemed I would vomit at any minute.

About six weeks after that incident, I developed a fever of 102°F, and I felt so sick that I went to see Dr Dymond. He conducted examinations to evaluate my heart, lungs, and stomach, and he then administered OMT to correct my cervical lesion. After the treatment, Dr Dymond told me to go home and rest in bed, which I did. By the next morning, my nausea and fever had disappeared, and I felt healthy. As far as I was concerned, I now had proof positive that OMT works!

As a result of these childhood experiences, I decided to pursue a career in osteopathic medicine. I studied at the Des Moines Still College of Osteopathy (now the College of Osteopathic Medicine and Surgery of Des Moines University) in Iowa. After graduation, I opened my practice on November 3, 1935, in Springfield, Minn, where I have lived ever since. From 1940 to 1970, I owned and operated the state-licensed Tessien Osteopathic Hospital in Springfield.

During a typical (long) day in my practice, I would see 40 to 70 patients, and 8 of 10 of them received OMT from me. When I provided OMT to my patients, the treatments were not always lengthy procedures, but they were long enough to correct my patients’ lesions.

When I retired in 1988, I had 53 years and 5 months of clinical experience as an osteopathic physician—perhaps the most extensive general practice in Minnesota—and I had administered OMT an estimated 400,000 times. These treatments were my main therapeutic procedure. The fact that so many people drove daily 20 to 120 miles for my OMT sessions indicates to me that no expensive trials of OMT are necessary. All that needs to be done to verify the efficacy of OMT is to consult old timers such as myself!

I think I know the main problem that the osteopathic medical profession faces today. After graduation, too many DOs intern in hospitals were OMT is never practiced, never mentioned, and, in some cases, even prohibited. So these poor, partially educated DOs never really get an opportunity to use OMT as it should be used.

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Editor’s note: Dr Tessien is the author of My Practice of Osteopathic Medicine: Complete Works (Kuchera Press; 1999).