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Beware of combining erythromycin with a statin

To the Editor:

For the first time in 40 years as a scientist, I have information I believe is so important that I want to share it immediately with as many people as possible. The medical community and the public need to know about the increased risk of cataracts associated with concurrent use of the common antibiotic erythromycin and cholesterol-lowering statins. Among the most prescribed drugs in the United States, statins work by inhibiting cholesterol biosynthesis. The review of patient records at the University Hospital of Basel, Switzerland, by Christopher Meier, PhD, MSc, and our studies with animals at the Kirksville College of Osteopathic Medicine indicate that brief exposure to high blood levels of statins can markedly increase the risk of cataracts in humans and animals. Results of the case-controlled analysis by Schlienger et al revealed that a single course of erythromycin therapy combined with simvastatin doubled the risk for cataracts and that two courses of erythromycin with simvastatin tripled the risk for cataracts. Erythromycin can block the metabolism of many statins and vastly increase blood levels of cholesterol-lowering drugs.

In January 2003, we reported that treatment of a specific strain of rats (Chbb: Thom) with a high dose of simvastatin for 2 weeks committed the ocular lens to forming cataracts. We believe this strain of rat has a defect in regulating one of the key enzymes in cholesterol biosynthesis that prevents it from defending against stress caused by high blood levels of simvastatin.

Combining drugs other than erythromycin with statins may also place the eye at increased risk. These drugs include verapamil hydrochloride, cyclosporine, itraconazole, and ketoconazole. Each drug can inhibit the metabolism of simvastatin, atorvastatin calcium, cerivastatin and lovastatin by the cytochrome P450 system. Therefore, great care should be taken when combining any of these drugs with statins.

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References

Time to forge affiliations between osteopathic medical schools and hospitals

To the Editor:

When my wife and I moved to south Florida a few years ago, we asked neighbors where they go for healthcare needs. They told us that they go to the airport—an interesting response. We soon found that although there are some good physicians and a few adequate community hospitals in our community, there is a lack of academics in our area. There are no teaching hospitals nearby, no residency programs of note, and no recognizable affiliations with the local osteopathic medical school or the allopathic medical school in Miami, Florida. I trained and practiced in the Northeast, which was abundant in predoctoral and postdoctoral educational programs. As an intern and resident and later as a faculty member of a teaching hospital, I was constantly involved with case reports, teaching rounds, journal clubs, conferences, and challenges from house staff.

The most explosive thing in the world is an idea. Besides brimming with fresh ideas, residents often have healthy aggression, inquisitive minds, and enlightened attitudes. As a result, many original and stimulating research papers have come from our resident programs. As an attending physician, it was gratifying to channel that energy into areas of clinical and laboratory research. It was fun to discuss new ideas and developments in our field of practice. Hospital residency programs foster an atmosphere of enlightenment and an atti-
A proposal that benefits all

To the Editor:

The article by Shirley M. Johnson, PhD, MPH, MSW, and Margot E. Kurtz, PhD, “Conditions and diagnoses for which osteopathic primary care physicians and specialists use osteopathic manipulative treatment” (J Am Osteopath Assoc. 2002;102:527-540), points out what most osteopathic physicians have known for a long time: Osteopathic manipulative treatment (OMT) is being used less and less by osteopathic physicians. I believe that if we, as osteopathic physicians, do not use OMT in our practices, osteopathic medicine will cease to exist as a separate profession.

Some osteopathic physicians believe that the profession has produced little scientific evidence to prove that OMT is of value for treating musculoskeletal complaints and less evidence that treating segmental-related somatic dysfunction improves the outcome of patients with visceral disease. Other osteopathic physicians are willing to accept the value of OMT for the treatment of musculoskeletal and visceral complaints but believe that the procedure is an inefficient use of time. Therefore, many osteopathic physicians fail to learn or to use necessary techniques to practice OMT effectively.

What strategy can the osteopathic profession implement to maintain itself as a vital, separate philosophy of medicine as proposed by A.T. Still, MD, DO? We are doomed if we believe we are solving the problem by preaching to osteopathic physicians that they need to learn OMT and use the procedure in their practices. This will not reverse the trend of osteopathic physicians using less and less OMT.

Besides producing scientific evidence confirming what many osteopathic physicians know intuitively regarding OMT’s effectiveness, I believe it is time to consider a new concept that will provide the practicing osteopathic primary care physician and osteopathic specialist the means to incorporate OMT in their practices. The concept involves creating another layer of osteopathic medicine providers—providers trained in osteopathic medical diagnosis and manipulative treatment who practice under the guidance of osteopathic primary care physicians or specialists. The position would be similar to that of a physician’s assistant and could be called an osteopathic manipulative assistant. This assistant would be trained at existing osteopathic colleges of medicine, joining osteopathic medical students for the first 2 years of education and then completing a 1-year internship in OMT.

An expanded student population and the resulting increased revenue would help secure the financial stability of osteopathic medical schools. The osteopathic manipulative assistant would become a partner in delivering osteopathic medical care. Osteopathic physicians would be able to bill for these services in the same way that physicians bill for the services of physician assistants and nurse practitioners. This would bring added revenue to the practice and provide OMT to patients who would not ordinarily receive the treatment. Implementing the proposal will secure osteopathic medicine as a separate medical profession, increase enrollment in colleges of osteopathic medicine, and provide OMT to a greater number of patients.

This suggestion might be considered absurd by some osteopathic physicians, especially those who have devoted their lives to the specialty practice of OMT and those in the colleges of osteopathic medicine who have spent their lives teaching OMT, but I believe it would benefit them greatly. Physicians who use OMT in their practices would have extenders allowing them to see more patients and therefore survive the problem of ever-diminishing reimbursement for services, as these physicians have so few billable codes available to generate income. Those who teach OMT would have an enthusiastic group of students who are committed to learning and practicing OMT. The primary care specialist would also benefit by having more billable services to render and by being identified as a unique healthcare provider who offers comprehensive care in an ever more competitive environment. Patients would perceive that they were receiving better care for their healthcare dollars when visiting an osteopathic physician whose practice provides OMT regularly.

Greater numbers of patients are recognizing the value of manipulative therapy, but they are going to providers outside the osteopathic medical profession for this care.
The practices of chiropractors, physical therapists, massage therapists, and other body manipulation providers are flourishing and competing with osteopathic physicians for the medical dollar. I believe that dialogue about the value of this proposal should be entertained by the leadership of the osteopathic medical profession and by leaders of colleges of osteopathic medicine.

Emmett M. Bentley, DO
St. Louis, Missouri

Intern on call

He rises in the dead of night
From the bowels of the earth
Where he was curled beneath a white sheet.
Nestled
Under Same Day Surgery
Dreaming
of hands reaching out to him.
He is comfortable
Three doors down from the morgue.
He wipes sleep from his eyes,
Pats down his tousled hair,
And turns on the light.
Somewhere above him
He is needed.
He finds her on the third floor.
Lost
Confused and betrayed by shadows
And voices that tell her lies,
Stealing her breath.
She reaches a fragile blue-veined hand
Toward his face.
“Is the doctor,” he says. “Can I help?”
The words hold magic in the night.
Power
This power is so new to him
He isn’t sure he believes in it,
But she has faith enough for them both.
He assesses, he notes, he orders
All the things he thinks are right.
Then goes back beneath the ground,
Slides under the cool, white sheet,
And dreams of the hands.

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Medical Evaluation of Child Sexual Abuse: A Practical Guide


Past president of the American College of Osteopathic Pediatricians, Martin A. Finkel, DO, and coauthor, Angelo P. Giardino, MD, have collected and edited a compendium so powerful that it may ultimately become the definitive text on child sexual abuse.

Dr Finkel, Director of the Center for Children’s Support at the University of Medicine and Dentistry of New Jersey, is one of those rarities—an osteopathic physician whose book is going into a second printing. Quite a recommendation.

Although comprehensive and minutely detailed, the book never becomes pedantic, and although all aspects of evaluating child sexual abuse are thoroughly covered—medical, legal, forensics, sexually transmitted diseases, nursing, psychological—the book never loses sight of its primary goal: concern for the care and treatment of children. The authors stress that goal by using repeated and varied emphases throughout the book.

Although chapters are written by several authorities, each preserves the continuity and easy reading of the text, and all are outstanding. Scattered throughout the volume are illustrations, figures, and sidebars with detailed explanations, which aptly expand the text. However, the chapter “Medical Evaluation and Physical Examination” is a masterpiece of information, with specifics that are most educational. The text’s approach to taking a medical history and talking with and examining a child could be a freestanding basic text in pediatrics.

In addition to cohesive chapters, Finkel and Giardino include 19 line drawings, 13 pages of colpophotographic case studies in full color, and an appendix of the most important questions parents ask, with appropriate answers that are exactly worded.

As I have known Dr Finkel since he was a child (which could conceivably influence my view of this book) and out of respect for him as a colleague, I sneaked a look at several other reviews to test my views. Unsurprisingly, those articles were at least as enthusiastic, laudatory, and commendatory as mine, and all of them strongly recommended use of the book.

This volume should be placed in every medical library and emergency room. It easily serves as a great backup reference for every primary care physician who sees children. It is also great leisure reading for anyone interested in this field. All uses of this book would greatly benefit children, which is the authors’ goal.

Arnold Melnick, DO
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