IMPACT OF ADVANCE DIRECTIVE VIDEOTAPE ON PATIENT COMPREHENSION AND TREATMENT PREFERENCES

GASTROESOPHAGEAL REFLUX DISEASE

PREVENTION ADVISE RATES OF WOMEN AND MEN PHYSICIANS

THE EFFECTIVENESS OF A MAIL REMINDER SYSTEM FOR DEPOT MEDROXYPROGESTERONE INJECTIONS

ACUPUNCTURE IN THE 1990s

ALCOHOL-ASSOCIATED DIABETES MELLITUS: A REVIEW OF THE IMPACT OF ALCOHOL CONSUMPTION ON CARBOHYDRATE METABOLISM
**HISTOPATHOLOGIC FINDINGS**

Compact hyperkeratosis and areas of scale-crust were seen. An intradermal tumor composed of lobulated, well-circumscribed squamous epithelium was seen extending to the subcutaneous fat. The lobules had a basaloid peripheral palisading layer and exhibited abrupt trichilemmal keratinization with formation of homogeneous keratin cysts. No cellular or nuclear atypia was seen. Foci of calcification and a lymphohistiocytic infiltrate were present.

**DISCUSSION**

Proliferating trichilemmal cyst is thought to arise from a preexisting ordinary trichilemmal cyst following trauma and inflammation.1,2 A PTC is often lobulated and can undergo ulceration greatly resembling squamous cell carcinoma (SCC).2,3 Multiple lesions have been reported.1,2,4 In 90% of cases, the tumor occurs on the scalp; in 10%, on the neck.1-3 There is a predilection for females (84%).1,3

On light microscopy, PTC can be confused with SCC at first glance. However, there are key differentiating histologic features. These include well-demarcated lobules of squamous epithelium with noninfiltrative peripheral palisading borders that rest on a thick hyalinized basement membrane.2,3 Although occasional foci with a slight degree of cellular and/or nuclear atypia and dyskeratosis may be present, PTC, unlike SCC, lacks severe dysplasia or invasion.2,3 The abrupt change from squamous epithelium to eosinophilic keratin (trichilemmal keratinization), identical to that seen in trichilemmal cysts and reminiscent of the outer root sheath of hair, favors PTC.2,3 Foci of calcification and dermal inflammation, usually lymphohistiocytic, are often associated with PTC.2,3

Due to the mode of differentiation, PTC is thought to be derived from the outer root sheath (follicular isthmus).2,3 In addition to trichilemmal keratinization, a form of cell maturation that occurs normally in the stratified epithelium of the follicular isthmus, PTC also features vacuolated glycogen cells typical of the outer root sheath.1,2

The differential diagnosis may include SCC, other adnexal tumors (ie, clear cell hidradenoma), deep fungal infection, and pseudop epitheliatous hyperplasia of bromoderma and iododerma. These entities can be excluded on histopathologic examination, since they do not demonstrate features characteristic of PTC. The PTC is considered a benign neoplasm; its treatment is surgical excision.1 There have been reports of malignant transformation with metastases.1,2 In these instances, the neoplasm rapidly enlarges and exhibits severe cellular atypia and invasion of surrounding connective tissue.1,2

**Selected from** Arch Dermatol. 1995;131:719-724. Off-Center Fold.

**REFERENCES**


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**Clinical Pearl**

Kids swallowing coins: if it is in the proximal or middle third of the esophagus, it probably will not pass spontaneously. If it is in the distal esophagus, observe; it may pass spontaneously. (Arch Pediatr Adolesc Med. 1995;149:36-39.)
situation, and it was left to me to find a job. At a time when I felt vulnerable, fragile, and punished for my illness, I had to go out and search for a new job. I talked with other clinics in my community, but they were not interested or comfortable in working with me.

Prior to my suicide attempt, I had heard positive comments about my work. I am a competent and caring physician. After I attempted suicide, no one in my community would work with me. I do not like being sick. It hurts to say I have a mental illness. The punishment and shame I felt from losing my job and being shunned by my medical community intensified those feelings. As Dr Bauman stated, "we expect perfect mental health in ourselves and in our peers." Only perfection will do. To deny our vulnerability to illness and its effects is to deny our human-ness. Is this the message we want to continue to convey in our profession?

I am now committed to being alive. I have a new job, 300 miles away from familiar surroundings and the people who could have provided support. I hope the day will come when depression is truly seen as a treatable medical illness in our colleagues as well as in our patients, so that job loss and personal rejection do not have to be the outcome of a failed suicide attempt.

Gayleen M. Eilers, MD
St Luke's Family Practice Residency Program
Milwaukee, Wis


In reply

I thank Dr Eilers for her courage in sharing her story. I was in academic family medicine at the time of my husband's unexpected and untimely death by suicide and I received excellent support in my recovery. This experience, plus the fact that family physicians take care of so many depressed patients, led me to believe family practitioners would provide an understanding and supportive environment for physicians like Dr Eilers. This may not be the case.

As I reflect now, I realize that people in general, not just physicians, are finally learning how to respond to a person who has had a loved one die. They can say, "I'm so sorry!" or even, "I just don't know what to say," and include a warm handshake or a quick hug. Faced with a colleague with a mental illness, physicians can be at even more of a loss for words. Instead of saying similar things, they say nothing, causing rejection and isolation.

Students often ask me, "What could people have done to be more helpful?" At risk of sounding like Ann Landers, perhaps I can suggest factors or ways of behaving that would have worked better for Jim and for Dr Eilers.

1. Physicians, like others, need adequate mental health insurance coverage that includes diagnoses such as depression, alcoholism, and substance abuse.
2. Send frequent cards or brief notes to colleagues who are recovering from any of these medical problems. Don't expect answers every time. Maintain your links to that physician.
3. Recognize a "teachable moment" for the office or department, and hold conferences on related mental health topics so all are informed and welcoming when the ill person has recovered sufficiently to return to work. Remember the high recovery rates for many of these diseases, for example, 80% to 90% for alcoholic and addicted physicians.
4. Involve the recovering physician in plans for his or her work schedule on return and the role he or she would like to play in continuing education on pertinent mental health topics. At times the recovering physician may choose to teach others as a part of his or her recovery process.
5. Allow time off for follow-up care.
6. Respect the confidentiality of the situation.

I would wish that we could create supportive environments in our workplaces so that, as Dr Eilers states, "depression is truly seen as a treatable medical illness in our colleagues as well as in our patients," and I would change her closure to, so suicide isn't attempted!

Kay A. Bauman, MD, MPH
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Mililani

Announcement

Free Patient Record Forms Available

Patient record forms are available free of charge to ARCHIVES readers by calling or writing FORMEDIC, 12D Worlds Fair Dr, Somersett, Nj 08873-9863, telephone (908) 469-7031.
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Dr Siegert was a geriatric fellow supported by the Department of Veterans Affairs during the conduct of this work.

The authors acknowledge with gratitude the assistance of Lane Beachamp, MSW, for data collection; Ronald E. Westlund, MA, Center for the Study of Aging and Human Development, Duke University Medical Center, Durham, NC, for statistical consultation; and Marion Danis, MD, University of North Carolina at Chapel Hill, for review of study design and data analysis.

Correspondence to Cooper Hospital/University Medical Center, Suite 215, Three Cooper Plaza, Camden, NJ 08103 (Dr Siegert).

REFERENCES


Clinical Pearl

Plasma homocysteine level appears to be a risk factor for carotid stenosis as well as coronary artery disease: the higher the plasma homocysteine level, the higher the incidence of the disease. Vitamins B6 and B12 and folic acid are needed for homocysteine metabolism and may be protective. Eat your fruits and vegetables (at least five servings a day.

The well-controlled evaluation by Siegert and colleagues showed that one method did not enhance comprehension or result in more informed decisions. In their final paragraph, the authors make good suggestions for interactive as well as culturally and educationally appropriate strategies for communication. More realistic expectations of the value of CPR and, more important, a clear understanding that no matter what we do, we cannot prevent our own deaths, must permeate our culture. When this occurs, we and our patients will be better prepared for learning about and understanding advance directives. We will also likely make wiser decisions about our preferences for treatment.

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Department of Family and Community Medicine
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REFERENCES


Clinical Pearl

Kidney stones: the combination of 16 mg of methyldenisolone and 40 mg of nifedipine per day is better than the use of steroid alone in encouraging passage of stones. The success rate is 87% compared with 65% (J Urol. 1994;152:1095-1098.)
cians, could improve the frequency of their prevention-related counseling practices, and that women might be especially effective leaders in this effort.

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Correspondence to Department of Family and Preventive Medicine, Emory University School of Medicine, 69 Butler St SE, Atlanta, GA 30303-3219 (Dr Frank).

REFERENCES


Clinical Pearl

For acute exacerbation of chronic obstructive pulmonary disease, magnesium sulfate (1.2 g over 20 minutes) improves peak flow (PF) (used with a β-agonist).

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<tr>
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<th>PF at 0 min, L</th>
<th>PF at 30 min, L</th>
<th>PF at 45 min, L</th>
<th>Hospitalization Rate, %</th>
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<tbody>
<tr>
<td>Magnesium sulfate</td>
<td>137</td>
<td>162</td>
<td>161</td>
<td>28</td>
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<tr>
<td>Placebo</td>
<td>137</td>
<td>143</td>
<td>143</td>
<td>42</td>
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The difference in hospitalization rate was not statistically significant. (Arch Intern Med. 1995;155:496-500.)


**Clinical Pearl**

Of magnetic resonance imaging scans of the shoulders of asymptomatic patients older than 60 years of age, 28% show full-thickness rotator cuff tears and 26% show partial rotator cuff tears. Of those patients aged 40 to 60 years, 4% show full-thickness tears and 24% show partial tears. All patients with tears had osteoarthritis. Thus, be careful ordering magnetic resonance images of the shoulder—will it change management? (J Bone Joint Surg Am. 1995;77:10-15.)
cussed above demonstrate that an understanding of the origin of diabetes mellitus can make a difference in treatment.

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Reprint requests to Department of Medicine (111E), Veterans Affairs Medical Center, 1000 Locust Ave, Reno, NV 89520 (Dr Lardinois).

REFERENCES


Clinical Pearl

The female condom: the 6-month pregnancy rate is 12.4%; the 12-month pregnancy rate is 22.2%. These rates are similar to other barrier methods. The rate of pregnancy was 3% at 6 months with perfect use. (Am J Public Health. 1994;84:1960-1964.)