Loss of dental support increases risk for ischemic stroke

To the Editor:

"To estimate a man's risk of ischemic stroke, ask him to smile. Then count his teeth. Men with 24 or fewer teeth had a 49% increased risk of ischemic stroke, compared with men who retained most of their teeth, in a study of 42,000 men reported by Dr Kaumudi J. Josipura while she was working at Harvard School of Dental Medicine, Department of Oral Policy and Epidemiology in Boston, Mass. This study was a poster presentation at the recent annual conference on cardiovascular disease epidemiology and prevention sponsored by the American Heart Association." (*Family Practice News*, May 15, 1999.)

Dr Josipura's statistical analysis describing the loss of dental support relative to the increased risk factor for ischemic stroke is an after-the-fact flag.

For a before-the-fact flag also related to a decrease of dental molar support, there is the first cervical somatic dysfunction. In my experience with the controlled non-traumatic induction of a first cervical somatic dysfunction, it requires the following to be present:

- ☐ decrease of molar tooth height (see dotted lines in *Figure 1*; see also *Figure 2*);
- ☐ depression of maxillary bone (see dotted lines in *Figure 1*), and zygoma (*Figure 2*);
- ☐ the condyle slides posterior in the fossa (see arrow, *Figure 2*);
- ☐ the C1 somatic dysfunction becomes palpable.

The foregoing information is based on 30 years of experience using removable mouthpieces called acrylic templates or "splints." These mouthpieces are individually fitted for patients based on the absence of palpatory findings of the C1 and C2 somatic dysfunctions.

The challenge with craniofacial manipulation is its effect on the optimal position and balance of the maxillary bones after osteopathic manipulation. The after-manipulation approach I have used during the

past 30 years requires the thin acrylic template or "splint" to be fitted over the back three lower teeth on both sides of the mouth. The small thickness variations on the acrylic surface are built in such a way that the right and left maxillary first molar lingual cusps are the balance point for the respective maxillary bone.

For our profession to make a major contribution requires the physicians-in-training to learn how to fabricate, fit, and balance acrylic templates or "splints," in my opinion. In this manner, we as a profession can meet the challenge of not only recognizing the C1 diagnostic flag, but also we can play our part in early intervention to reduce a risk factor of ischemic stroke for our patients as well as ourselves.

James E. White, DO
Medina, Ohio

Figure 1. An anatomic posterior oblique view of the right maxillary bone.

Figure 2. The diagrammatic illustration of C1 somatic dysfunction.

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Letters continued

Appreciation for the profession grows as physician returns to osteopathic roots

To the Editor:

I am writing to express a newfound appreciation for the integration of our profession. When I went into practice as a general internist 14 years ago trained in a hospital-based medicine program, my practice was divided 90% hospital and 10% office. Over the years as more subspecialists came to town, my practice gradually shifted to the opposite distribution: 10% hospital and 90% office. To my surprise, I enjoyed the continuity of care of the long-standing primary care patient, and I also enjoyed sleeping more hours in a row out of the hospital.

I also confronted more and more patients who wanted manipulation as a part of their care. When I confessed that I had not emphasized that in my training, I was faced with the uncomfortable questions, "Well, aren't you a DO?" I took the easy way out and brought over house staff from the hospital who could manipulate circles around my poor skills. But every once in a while, there would be no house staff available, and I would have to struggle through. Imagine my surprise when I could actually help to relieve some of my patients' discomfort.

This was the start of a journey that led me back to my roots and this year to the AOA convocation and a plan to prepare for the certification examination. This lone internist was warmly welcomed back into the fold. I have always been a DO, and I do not believe that manipulation skills define us as DOs. I believe that our approach to the patient as an integrated whole person is what defines us as DOs, but if you believe that, then you cannot ignore the visceral and somatic connections with all their attendant implications. I feel like a fledgling again, but I am enjoy-

ing the renewed challenge of being a whole physician.

I am delighted that my renaissance has come in time for the Unity Campaign. We have strayed, we have hurt each other, we have strained at gnats, and stumbled over pebbles, but we are still DOs. It is time to unify behind our identity and present a unified front to the world. I would like to see closer interaction between the specialty colleges, the state and affiliate societies, the colleges of osteopathic medicine, the hospitals, all our different interest groups. They say that home is where, when you go there, they have to let you in. Welcome home to the osteopathic medical family.

Karen J. Nichols, DO, FACOI

Phoenix, Ariz
1998-1999 President, Arizona Osteopathic Medical Association
Secretary-Treasurer, American College of Osteopathic Internists
Board Member, University of Health Sciences/College of Osteopathic Medicine
Third Vice President, AOA
Member, JAOA Editorial Advisory Board

What is the true cause of asthma?

To the Editor:

I read with great interest the article, "An osteopathic approach to asthma," by William A. Rowane, DO, FACOI, and Michael P. Rowane, DO, MS, FAAFP (JAOA 1999;99:259-264). These authors set a new standard in the clinical medical articles for the JAOA. It was a breath of "osteopathic fresh air" to see an article that has an osteopathic element and specific osteopathic manipulative treatment (OMT) techniques included. This should be the standard for all articles in the JAOA.

However, I do have some concerns that the article did not address. Specifically, why is the incidence of asthma increasing, why is the severity of asthma increasing, and most important, what are we doing to address the cause? It seems that with seemingly superior pharmaceutical agents and more aggressive care, our patients are worse, not better. What is the cause we are missing? It cannot be all pets, because many asthmatic patients do not have pets

and those that do do not get appreciably better when the animals leave.

The authors restricted their use of OMT in this article to the emergency setting; however, their pharmacologic and lifestyle changes are used beyond the emergency setting. What OMT do they suggest for the long term?

The authors made the statement, "the benefits of osteopathic manipulation seem obvious, but controlled clinical studies using OMT in asthmatic patients are needed." Although this is a statement of fact, such a sentence, in my opinion, should not have been printed. It comes across as being apologetic for the profession. We have nothing for which we should apologize other than our failure to hold fast to our philosophy of the structure-function relationship in all cases and our failure to consistently use it more than we do in patient care.

This profession was founded on a philosophy and built because of and by that philosophy. Andrew T. Still met the first research challenge of replication because he taught others his methods and they used them with positive results. And his successors did the same. True, there are no statistics, but we continue to exist despite some powerful attempts to make us disappear. We should use our osteopathic principles and philosophy and our OMT for the benefit of our patients based on our own belief and acceptance of those principles, philosophy, and techniques. We should also seek to show the effectiveness of approach as well.

The authors are to be commended for their work. I look forward to their next article in which they will address the long-term approach with OMT for the asthmatic patient.

Robert C. Clark, DO, MS

Chairperson, Osteopathic Manipulative Medicine Department
Touro University College of Osteopathic Medicine
San Francisco, Calif

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Managing asthmatic patient requires examination of the somatic system

To the Editor:

I read with interest the article, "An osteopathic approach to asthma," by authors William and Michael Rowane, DOs (JAOA 1999;99:259-264), and the two accompanying editorials. Regarding the authors' review of failures in "five areas involving asthma management," I encourage the engagement of a sixth failure. This one is, to me, of even more fundamental concern. Osteopathic management of the asthmatic patient implies an examination of the somatic system, tests for palpable cues to significant sites of disturbed neuromusculoskeletal behavior. Do these positive physical signs relate to the clinical problem the patient presents? Are they an intimate part of the problem? If so, then manipulation offers a viable option in osteopathic management. (An osteopathic manipulative treatment procedure should have more than a theoretic basis for what too frequently can become a routine application.) Study after study of "manipulation for pain" has displayed this same failure, that is, failure to document the related neuromusculoskeletal dysfunction intimately related to the pain.

William L. Johnston, DO, FAAO

Professor Emeritus
Department of Family and Community Medicine
College of Osteopathic Medicine
Michigan State University
East Lansing, Mich
Member, JAOA Editorial Advisory Board

Response

To the Editor:

We appreciate your valuable recommendations to continue to expand on the osteopathic emphasis from our article, "An osteopathic approach to asthma," published in the May issue of JAOA. Dr Johnston is the primary author of *Functional Methods: A Manual for Palpatory Skill Development in Osteopathic Examination*

and *Manipulation of Motor Function*, which is in our personal library. He makes a good point to expand on sites of possible disturbed neuromusculoskeletal behavior to assist in diagnosing and managing patients with asthma and other visceral disorders. We did acknowledge the primary sites to evaluate for somatic dysfunction (T1 through T6, especially on the left), which are cited in the osteopathic medical literature.¹ Our understanding of osteopathic philosophy teaches us that these reflex arcs involve viscerosomatic and somatovisceral reflexes, thus neuromusculoskeletal changes do have clinical implications and are intimately part of the problem. We strongly concur that osteopathic manipulative treatment (OMT) procedures should be more than cognitive experiences. This is another powerful argument for the use of OMT in the care of all our patients. Being more conscious of neuromusculoskeletal dysfunction's relationship to clinical signs and symptoms is a necessary concept that justifies our distinct branch of medicine.

Dr Clark brings up many questions on the state of asthma today, which as we agree, do not seem to make sense. We have painstakingly researched the data on the rising incidence and evolving severity of asthma today. We can only postulate on why this has occurred. In spite of an advanced pharmacologic armamentarium, the underlying cause is still in the hands of the bench and clinical scientists. This is frustrating for the osteopathic physician who has been trained repeatedly to search for the cause and not just treat the effect of any disease process.

Osteopathic manipulative treatment is a modality we personally use and promote as a part of the management of any asthmatic patient. Although we did use a specific example of using OMT in the emergency setting, it is not the only indication. Our reports from the osteopathic medical literature acknowledge multiple benefits of OMT to individuals with asthma, which supports its use in nonacute as well as acute situations. The most ideal situation is using OMT as a part of preventive care in all our patients.

We are sorry that you are concerned with our statement, "...the benefits of osteopathic manipulation seem obvious, but controlled clinical studies using OMT

in asthmatic patients are needed." It is an academic responsibility to be critical and evidence-based as a conscientious physician. We must continue to expand our studies on OMT to show why what we use works and what are the superior manipulative procedures and management plans to teach our students and practicing colleagues.

The responsibility to do research on the short- and long-term approach with OMT for patients with asthma and other visceral disease states, as well as musculoskeletal disorders, is the responsibility of every osteopathic physician. There has been a call for research on osteopathic manipulation with the leaders from both the osteopathic and allopathic medical communities in the Josiah Macy, Jr. Foundation symposiums in 1995 and 1996.² We would love to join leaders in our osteopathic medical profession, such as Drs Johnston and Clark, to be a part of this process.

William A. Rowane, DO, FACOI

Michael P. Rowane, DO, MS, FAAFP
Cleveland, Ohio

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Asthma article ignores role of allergy and immunotherapy

To the Editor:

After reading your excellent editorial on asthma in the May issue of JAOA, and reading the article, "An Osteopathic Approach to Asthma," by William A. Rowane, DO, FACOI, and Michael P. Rowane, DO, MS, FAAFP, I am very disturbed by what has to be considered a significant omission. The article by the Drs Rowane totally ignores a huge category

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Letters continued

of medical research relative to the pathophysiology and treatment of asthma: namely, the role of allergy and immunotherapy.

"Environmental triggers" are mentioned, but there is no mention of definitive identification of these environmental triggers via allergy testing. There is no mention of the significant body of research showing the importance of dust mite sensitivity and cockroach antigen sensitivity in the etiology of asthma both in urban and rural areas. Likewise, there is no mention of the fact that several of the large managed care companies have data showing that the total cost of care of the asthmatic patient and the incidence of hospitalizations and other episodes of morbidity in an asthmatic are least when the asthmatic patient is under the supervising care of an allergist. Likewise, there is no mention of the role of pollens, food allergens, or mold allergens in the asthmatic patient in this article. The article by the Drs Rowane spends time talking about ozone, nitrous oxide, and sulfur dioxide in triggering asthma attacks relative to the outdoor air, almost quoting verbatim the National Institute of Health (NIH) guidelines, and makes no mention whatsoever of specific airborne allergens. There is mention of some indoor allergens, but no mention of specific treatment via specific immunotherapy for these etiologic agents.

We have a large body of peer-reviewed scientific research showing the prime importance of allergy in the etiology of asthma. Indeed, the *Guidelines for the Diagnosis and Management of Asthma* published by the NIH, as part of the ongoing National Education and Prevention Program, clearly states that patients with persistent asthma, requiring medications, should undergo allergen identification. That publication also gives mention to immunotherapy. Although I have not scanned the final product for the following two statements, the prepublication draft of this document, which was sent to me for review, clearly stated the following:

□ that at least 78% of patients with asthma had significant allergies; and

□ that immunotherapy was the only therapy that held out the "possibility of cure" in the treatment of the asthmatic.

Last, there was no mention of another very important etiologic factor, at least in the reduction of symptoms, especially in nocturnal asthma, that is, the role of gastroesophageal reflux disease (GERD). Certainly, we also have a significant body of research data pointing to the potential role of GERD in the production of asthmatic symptoms, therapy resistance, etc.

Any holistic approach to the diagnosis and treatment of the asthmatic patient therefore, in my opinion, must include allergen identification and evaluation for GERD. For example, it is fine not to allow any cats in the house of the asthmatic, but cat allergen is everywhere people go. As you may be aware, many asthmatics have problems on commercial airline flights, and it has been determined that cat antigen is in significant concentration in the air on commercial airliners. The only way in which there is any hope to prevent attacks due to cat allergen exposure is with desensitization therapy, and the same can be said for mite allergen and cockroach allergen, and the efficacy of some has been proven in the laboratory by challenge testing.

In conclusion, I was disappointed that neither the editorial nor the review article said anything about significant specific allergen identification, immunotherapy, and GERD in taking a holistic approach to the patient with asthma. The NIH National Asthma Education and Prevention Program is never going to be successful as long as the current medical literature ignores important elements of the guidelines. As a member of the Quality of Care for Asthma Committee of the AAAAI, it is of great concern to me to see review articles published that ignore or give short mention to very important aspects of the diagnosis and treatment of the asthmatic patient.

Rolf E. Gryte, DO, FACOI†

Member, American Academy of Allergy,
Asthma and Immunology
Osage Beach, Mo

Editor's Note: Dr Gryte died on September 11, 1999.

Response

To the Editor:

We appreciate your review and critique of our article, "An osteopathic approach to asthma," appearing in the May 1999 issue of the *JAOA*. This was a review article endeavoring to present a retrospective survey of asthma as we have studied and experienced this challenging disease as primary care physicians. We do not pretend to be pulmonologists or allergists; however, we have referred our patients to these specialists for consultation and management when we deemed necessary. It is always a precarious journalistic exercise when you attempt to encompass the alpha and omega of a human affliction and fail to become encyclopedic.

One of us (W.A.R.) has moderately severe asthma and has been through the valley of the shadows with this disease for the past 17 years. He had inhaled allergies with specific sensitivities. He consulted one of the leading authorities on asthma and immunology, a research scientist at the National Jewish Medical Center in Denver who later chaired the allergy department at a leading school of medicine. After a lengthy period of immunotherapy, he had no positive results. We know that one robin does not signify spring, and we continue to be optimistic about this approach, but in the meantime, thank God for inhaled steroids.

Asthma is one disease with an exhaustive and extensive body of knowledge in relation to its pathophysiology without a final resolution of the disease. Some authorities think that asthma represents multiple etiologies. Many asthmatic patients have a serious concern about dying from this disease. I am not including the very severe labile patients or the inner city impoverished asthmatics, but the average patient with moderately or moderately severe asthma who has breakthrough periods when breathing can create a very anxious experience. We know that the pulmonologist will say you are inadequately controlled, while the allergist will say you neglected immunotherapy. We have talked to many patients who have been there and have seen their allergist and their pulmonologist but face this ominous episode that

makes them feel that in that terrifying moment, they challenge an eternal edge. One of us knows this as he has also been there. Our paper was dedicated to this large group who could face these serious periods. We tried to classify these so-called failures of identification to anticipate and modify the progression of these ominous symptoms.

In his letter, Dr Gryte addresses the issue of a possible cure with immunotherapy and states that several large managed care companies have data showing that the total cost of care and the incidence of morbidity of the asthmatic patient is the least under the care of the allergist. We would be anxious to review these studies and the number and specific companies. With 17 million American asthmatics, more than 5000 deaths each year, and a gradual increase yearly in mortality, and a constant search for new pharmacologic agents, this document you write about would be very important to all of us who are interested in this challenging disease. As physicians and an asthmatic, we look forward to the case studies, research, and references this paper will reveal.

William A. Rowane, DO, FACOI

Michael P. Rowane, DO, FAAFP, MS
Cleveland, Ohio

Encourage children to become physicians

To the Editor:

For many years, I have heard other physicians say that they would not encourage their children to become physicians.

This statement has always been astounding to me. We all become discouraged from time to time over the pressures of our job. We live under the constant threat of litigation and increasing controls by both government and managed care. I am sure to some it seems more than one should have to endure for providing such a useful and compassionate service to society.

But get a grip! Why would you *not* want your child to be a physician? When compared with the lives of most other

folks, it is a pretty darn good way to make a living. Let us look at the situation a bit more realistically. As physicians, we are in the top 2% income-earning category in America. We possess enormous freedom of choice within our profession. We can choose to live wherever we want and change our minds as often as we like. We do work that reaps tremendous personal satisfaction and reward.

Compare all this with what the best corporate positions in America offer. In the real world of corporate America, someone is always telling you where to live, what to do, and when to do it. Medicine is one of the last few jobs that I can think of where you are still your own boss. In addition, even in the best corporate jobs in America, you are always under the threat of unemployment. I do not know of any unemployed physicians in America unless they choose to be.

So, if all we want for our children is for them to be happy and prosperous, I ask you what is wrong with being a physician? From my perspective, not much! I hope my children choose medicine for their life's work and pray that they will have as happy and prosperous a career as I have had.

Steven R. Eckstat, DO

President, Polk County Medical Society
Member, National Advisory Committee on Rural Health
University of Osteopathic Medicine and Health Sciences
Des Moines, Iowa

Empowering patients to treat themselves

To the Editor:

I read the letter by Howard M. Levine, DO, in the April issue describing a self-administered manipulation for a rib restriction with great interest (JAOA 1999;99:198). I also use self-treatment techniques and teach them to selected patients. I believe that teaching patients to treat their own somatic dysfunction empowers them to take responsibility for their health, a hallmark of truly holistic care.

Some of our osteopathic medical schools, however, appear to disagree. I have heard faculty at several schools advise against teaching self-administered manipulation. Reasons commonly cited for discouraging self-mobilization of joints include that it predisposes to hypermobility and subsequent degenerative changes, and that it only moves secondary somatic dysfunctions but is unable to free major restrictions. These possible side effects and complications are not discussed in any of the major textbooks on osteopathic manipulative medicine (OMM).¹⁻⁵ A 30-year Medline literature search failed to reveal any research or theoretic articles substantiating the association between self-mobilization and hypermobility or degenerative joint disease.

It has been my experience after 10 years of OMM practice that most patients can benefit from a prescription of self-administered manipulation, including joint mobilization techniques. Increased pain develops in only a minority of patients as a result of escalating frequency of self-mobilization in a process akin to psychological and physical dependence. Should all patients be denied this potentially helpful therapeutic modality when only a small percentage will develop dependence on the treatment, predisposing them to a theoretic risk?

For second rib dysfunction, I use a similar technique to Dr Levine's, but with a fulcrum pushing on the involved rib angle by lying supine and rocking on the rib. I tried his inhalation method, and it does facilitate rib mobilization.

I am preparing a compilation of self-administered manipulations for publication, including soft tissue, counterstrain, myofascial release, articulatory, muscle energy, and even high-velocity and low-amplitude techniques. I request permission to include Dr Levine's rib technique and would welcome any comments or additional techniques from other osteopathic physicians.

David R. Essig-Beatty, DO

Associate Professor of Osteopathic Principles and Practice
West Virginia School of Osteopathic Medicine
Lewisburg, W Va

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Letters continued

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A tribute to physician mentors

To the Editor:

I am currently in my second year of medical school at Lake Erie College of Osteopathic Medicine. Recently while talking with other students, I realized that everyone of us had a small group of physicians to whom we turned for guidance. Moreover, each one of us had one particular physician who had the most effect on our lives and whom we truly admired.

I wrote the following poem, *The Uncertainty of Dreams*, in tribute to those physicians who have taken time to guide us, would-be physicians of the future. It is also a reflection on how as students sometimes we question whether we will be able to reach the same level of greatness as those physicians. Of course, I am not excluded from that group of students, for myself this poem is about Thomas Masters, DO, of Erie, Pa. I am sure it will make every student think of someone different.

Tonya N. Bercik, MS II
Edinboro, Pa

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JAOA CME quiz

The purpose of this quiz is to provide a convenient means of self-assessment of your reading of the scientific content of this issue of JAOA. Enter your answers to the questions in the spaces provided so that you can easily check them with the answers that will be published next month.

To apply for CME credit, transfer your answers to the application form and answer sheet on page 540 and mail it to the CME office. So that you may complete this self-assessment in privacy, use only your member number to apply for CME credit. The CME office will record only the fact that you have completed the self-assessment test. Any grading will be done by the Editorial Department only for the purpose of planning areas of study which may be helpful to cover in future issues of JAOA.

1. What standardized form has been tested and validated which can be used in place of the physician's progress notes and can standardize research data collection in the outpatient setting?
____ (a) RAND 36.
____ (b) Outpatient Osteopathic SOAP Note Form.
____ (c) GHAA (Group Health Association of America).
____ (d) Osteopathic Musculoskeletal Examination of the Hospitalized Patient.
____ (e) All the above.
2. What preoperative procedures can help to confirm the diagnosis of agenesis of the gallbladder in a symptomatic patient that presents with an ultrasonic impression of small contracted gallbladder with stones?
____ (a) Endoscopic retrograde cholangiography.
____ (b) Operative cholangiography.
____ (c) Radionuclide hepatobiliary imaging.
____ (d) All the above.
____ (e) None of the above.
3. Which of the following is considered first-line therapy for gastric leiomyosarcomas less than 6 cm in diameter?
____ (a) Open en bloc excision and extended total gastrectomy.
____ (b) Laparoscopic wedge gastrectomy.
____ (c) Total and partial (distal or proximal) gastrectomy.
____ (d) Enucleation.
____ (e) None of the above.
4. Which of the following is not a prognostic factor affecting survival and recurrence of gastric leiomyosarcoma?
____ (a) Size of the tumor.
____ (b) Metastasis.
____ (c) Age at diagnosis.
____ (d) Histologic grade.
____ (e) DNA ploidy of the tumor.
5. Which of the following is not true regarding testicular cysts?
____ (a) Occurrence of simple testicular cysts is extremely rare.
____ (b) Testicular cysts generally are asymptomatic.
____ (c) Testicular cysts include simple intratesticular cysts and cysts of the tunica albuginea and testicular epidermis.
____ (d) It is difficult to distinguish testicular cysts from malignant testicular tumors.
____ (e) None of the above.◆

Letters continued

The Uncertainty of Dreams

If I say he's a hero to me,
It seems childish at age twenty-three.
But, how else can I explain,
He is everything I want to be.

You ask me, what makes him my hero,
I am not really sure if I know.
Yet, it is seen very plain,
That he is an outstanding D.O.

It can't be because he's a doctor,
I know a hundred doctors or more.
There's something special in him,
Such that by his patients he's adored.

It's his insight and treatment each day,
The caring and concern that's his way,
Makes me strive to be like him,
When I become a D.O. someday.

Each day I go to school, as I should
Each test I've done as well as I could.
Success, so close, but so far,
Question! Will I ever be that good?

It it comes from within I'll succeed,
There's nothing less in my life I need.
I can feel inside my heart,
Somehow, all my dreams will be achieved.♦

—Tonya N. Bercik, MS II

All opinions expressed in the JAOA are those of the authors and not necessarily those of the editors, the AOA, or the institution with which the authors are affiliated. Letters may be e-mailed to letters@aoa-net.org or they may be mailed to the Letters Editor, AOA, 142 E Ontario St, Chicago, IL 60611. No unsigned letters will be considered for publication.

JAOA

Editorial comments

Women who have severe psychological stress at or near the time of conception may be more likely to have a baby girl, report researchers.

The research supports earlier studies that have found the proportion of male infants declines after natural disasters such as earthquakes.

In a group of 3072 women who had some sort of traumatic stress around the time of conception, the proportion of boys was 49%, compared with 51.2% in 20,337 women who were less stressed during the time around conception.

The closer the traumatic event was to conception, the lower the odds of having a male baby, according to researchers at the John F. Kennedy Institute in Glostrup, Denmark. The stress group included women who lost a partner or child, were hospitalized for cancer, or had a heart attack in the year leading up to conception or during the first trimester of pregnancy.

The study can be found in the August 28 issue of the *British Medical Journal*.

The increased use of prescription medications may be contributing to high rates of obesity.

Psychoactive medications and steroid hormones along with drugs for hypertension, diabetes, and gastrointestinal disorders caused patients to gain the most weight.

The study can be found in the September issue of the *Southern Medical Journal*.

An exercise treadmill test can help to predict those with a higher risk for later heart attack or cardiac death.

A team of researchers at the Mayo Clinic in Rochester, Minn, followed up 939 patients whose resting electrocardiograms (ECGs) showed abnormalities in the T wave and ST segment. These patients were com-

pared with 1466 patients with ECGs showing normal T waves and ST segments.

After being injected with thallium, all patients took the treadmill test. Patients were classified into three categories: low risk, intermediate risk, and high risk. There were significant differences among the three groups for patients with ST segment and T-wave abnormalities.

The study can be found in the September 15 issue of *JAMA*.

The risk of prostate cancer is only slightly dependent on eating certain types of fat.

The dietary habits of 642 men in whom prostate cancer developed were compared with those of 1525 men who did not have the disease. Consumption of oleic acid, which is found in canola oil, corn oil, and olive oil, may cause a slight increase in risk, whereas consumption of linoleic acid and linolenic acid, which is found in fish and canola and linseed oils, caused a slight decrease in risk.

The study can be found in the September 15 issue of *Cancer*.

Pregnant women who go to hospital emergency departments with asthma attacks may not receive appropriate care.

Researchers studied 36 emergency departments in 18 states. They followed the treatment and progress of 51 pregnant women and 500 nonpregnant women who went to the emergency department with severe asthma attacks.

Only 44% of the pregnant women received corticosteroids, whereas two thirds of the nonpregnant women received steroids. Corticosteroids are recommended for treating asthma during pregnancy.

The study can be found in the September issue of the *American Journal of Respiratory and Critical Care Medicine*.