

COMMENTS AND RESPONSES

Late Sequelae of Induced Abortion

TO THE EDITOR: I was surprised to read the review of induced abortion by Grimes and Creinin (1). Several years ago, Dr. Grimes stated, "Traditional review articles are not just obsolete; they also are nonreproducible and of low scientific quality . . . [O]ne analysis . . . found a significant inverse relationship between adherence to scientific standards for a literature review and the self-professed expertise of an author" (2). Indeed, Grimes and Creinin's current review seems to bear this out, being crippled by selective literature citation and hyperbole.

Grimes and Creinin stated that abortion has no effect on future reproductive function and cited a 14-year-old review article. They ignored a more recent review that reached some different conclusions (3). While citing a 12-year-old commentary as proof that there is no "postabortion trauma syndrome," they failed to mention the limited follow-up periods that hamper most research regarding psychological implications of induced abortion. They also neglected to discuss 2 recent large studies demonstrating increased deaths from suicide in women who have had abortions compared with women who carried their pregnancies to term, in both Finland (4) and the United States (5). Regardless of whether this association is one of causation or of common underlying risk factors, it cannot be ignored. A patient seeking an abortion appears to be at higher risk for suicide. Surely this is information relevant to internists.

Grimes and Creinin cavalierly characterized 3000 pregnancy care centers as "biased counseling centers." At the same time, they recommended the National Abortion Federation and the Planned Parenthood Federation of America, both organizations with a vested interest in the provision of abortion. To insinuate that these organizations aren't biased while stating that pregnancy care centers are disingenuous at best.

Finally, given the target audience of internists, it is a glaring oversight that Grimes and Creinin's review does not specifically mention abortion and patients with medical conditions. Internists care for patients with significant medical problems who become pregnant. Many of these patients, and some physicians, may presume that induced abortion is the management of choice, a presumption often based on misinformation or outdated thinking. In these cases, referral to an obstetrician or a maternal-fetal medicine physician for evaluation and counseling should be considered. This provides the patient an opportunity to exercise her autonomy in a thoroughly informed context.

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1. Grimes DA, Creinin MD. Induced abortion: an overview for internists. *Ann Intern Med.* 2004;140:620-6. [PMID: 15096333]
2. Grimes DA. Evidence-based medicine: keeping your practice from getting stale. *Contemporary OB/GYN.* 1999;Jan:41-54.
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4. Gissler M, Hemminki E, Lonnqvist J. Suicides after pregnancy in Finland, 1987-94: register linkage study. *BMJ.* 1996;313:1431-4. [PMID: 8973229]
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TO THE EDITOR: Many feel that *Annals* is the voice of internal medicine in the United States. The journal has generally printed balanced views of controversial subjects. However, Grimes and Creinin's review on induced abortion (1) is a deplorable example of biased writing. It whitewashes the long-term medical and spiritual complications of abortion. The bland statements that "induced abortion does not harm women's emotional health" and that "it allows an overall improvement in quality of life" are outright lies, in my experience. The additional statement that the "'postabortion trauma syndrome' does not exist" is contradicted by well-attended postabortion support groups in many churches in my city. To prevent young physicians and medical students from being misled, it is of paramount importance that *Annals* present the opposing view.

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Reference

1. Grimes DA, Creinin MD. Induced abortion: an overview for internists. *Ann Intern Med.* 2004;140:620-6. [PMID: 15096333]

IN RESPONSE: We agree with Dr. Hoeldtke that systematic reviews of the literature are superior to narrative reviews. However, our article was invited as a primer for internists, not as a systematic or narrative review. Hence, our citation of the literature was by nature incomplete.

Dr. Hoeldtke makes a common error in logic regarding potential late sequelae of abortion: post hoc ergo propter hoc reasoning (after the fact, therefore on account of the fact). That one event (for example, suicide) follows another event does not imply a causal link between the two. In a notable example of this erroneous reasoning, Dr. Reardon, the lead author of the fifth reference in Dr. Hoeldtke's letter, has argued in print that penile amputation with a kitchen knife is a late consequence of abortion (1).

Many pregnant women with serious medical or psychiatric disorders choose induced abortion, as do many who live in abusive or violent relationships. Abortion does not remedy these comorbid conditions, including depression. Such women continue to have higher-than-average risks for morbidity and mortality. A recent population-based Finnish study documents this phenomenon (2). Rates of pregnancy-associated death from natural causes were higher in women who had induced abortions than in women after childbirth. When women who had abortions for medical reasons were excluded from the analysis, the rate was lower than that after birth.

Congressional hearings identified hundreds of counseling centers that deceptively portray themselves as abortion clinics. These centers have been documented to "detain, harass, and coerce women" (3). Regardless of one's views on abortion, such behavior is unethical. Facilities such as Planned Parenthood clinics do not promote abortion; instead, they support patient choice regarding pregnancy options. Planned Parenthood affiliates routinely counsel about adoption, and 21% provide prenatal care.

Because of space limitations, our primer on abortion could not

cover abortion for women with medical conditions. Recent texts cover this important issue in more detail.

Dr. Stone accuses us of misrepresenting psychological sequelae; personal experience and church groups in Nashville, Tennessee, constitute his supporting evidence. As Surgeon General C. Everett Koop commented about his 1989 report on abortion, "Anecdotes do not make good scientific material." Thorough (and recent) reviews of the literature refute the notion of long-term adverse emotional consequences of induced abortion (4, 5). This was the conclusion of both the Koop report and a special panel of the American Psychological Association.

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Costs of False-Positive Cultures from Central Catheters

TO THE EDITOR: We commend Raad and colleagues for their excellent research using differential time to positivity to diagnose catheter-related bacteremia (1). Although the test seems to have excellent sensitivity and specificity, the authors do not discuss the consequences of the sample collection strategy required to measure differential time to positivity.

In Raad and colleagues' study, 216 (3.5%) of the 6138 total paired specimens were positive on both the central and peripheral blood cultures, thus allowing differential time to positivity to be measured. However, drawing 1 central and 1 peripheral culture also resulted in 603 (9.8%) paired samples in which the central blood culture was positive but the peripheral blood culture was negative. This combination of results is uncommon in true bloodstream infection and is more likely to represent colonization of the central venous catheter. It is clear that catheter-drawn blood cultures are more likely to be false-positive than cultures obtained through venipuncture (2). Such false-positive blood cultures have been associated with inappropriate antibiotic use and increased costs (2-4) and can lead to inappropriate catheter removal or delayed diagnosis of the disease process that is truly causing fever.

The Infectious Diseases Society of America has issued guidelines suggesting that 1 central and 1 peripheral blood culture are appropriate in the work-up of critically ill patients with new fever (5). Nevertheless, physicians in clinical practice must weigh the potential benefits of the differential time to positivity test against the potential risks of the high false-positive culture rate associated with the required sample collection strategy. It would be interesting to study whether the same laboratories, equipped to accurately measure time to positivity, could help distinguish catheter colonization from infection.

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CLINICAL OBSERVATION

Editor's Note: The lead author of the following Clinical Observation was one of a dozen Associates of the American College of Physicians selected to present a clinical vignette at the 2003 Annual Session in Philadelphia. We are proud to present this case report through a special arrangement with the Council of Associates of the College.

An "Inexcusable" Case of Muscle Rigidity and Shortness of Breath

TO THE EDITOR: A 60-year-old man reported to the emergency department with shortness of breath. Three weeks before admission, the patient was in his usual state of good health when he sustained a left arm laceration from barbed wire trauma. The wound became red, hot, and purulent several days after this incident. The patient developed increasing left-arm stiffness that progressed to generalized muscle rigidity. On presentation the patient was acutely short of breath and cyanotic and was holding his mouth open to breathe. The patient was promptly intubated for airway protection, sedated, and transferred to the intensive care unit.

Medical history was significant for mild emphysema with a 50-pack-per-year history of cigarette smoking. The patient lived in rural Alabama and had not traveled recently. He had received his last tetanus booster in 1984 and had no known recent immunizations or previous military service.

Physical examination results showed a body temperature of 37 °C, a heart rate of 120 beats/min, a blood pressure of 103/45 mm Hg, and a respiratory rate of 24 breaths/min. The patient was in acute respiratory distress and cyanotic. Head and neck examination revealed markedly increased tone in the masseter muscles and contraction of facial muscles, including the orbicularis oris. The neurologic examination demonstrated diffuse, board-like muscle rigidity and paroxysms of violent generalized muscle spasms that involved arching of the back, flexion of the arms, and extension of the legs. The patient was areflexic in the upper and lower limbs and demonstrated decreased range of motion on repetitive movement. The left upper extremity was marked by a tender, indurated 3 cm-by-1 cm wound with scant purulent drainage.

The limited differential diagnosis included generalized tetanus, strychnine poisoning, hypocalcemia, and dystonic reaction. Laboratory results and blood and wound cultures showed no specific cause. On the basis of clinical impression, generalized tetanus was diagnosed.

Our patient had a protracted course that included passive and active immunization to tetanus, wound debridement, mechanical ventilation, and medical management of symptoms. Metronidazole was administered for wound infection and generalized tetanus coverage. The patient's severe paroxysmal muscle spasms were treated with continuous intravenous benzodiazepine therapy. After 6 weeks, he emerged from the intensive care setting and was discharged with minimal disability.

Rare in the developed world, with only 43 cases annually in the United States (1), tetanus is common in developing countries. Most U.S. tetanus cases occur in persons with inadequate or unknown vaccination who sustain an acute injury. Remarkably, from 1998 through 2000, no U.S. patients with tetanus who had current tetanus toxoid vaccination died (1).

Edsall labeled tetanus as "the inexcusable disease" over a quarter-century ago. He noted that most patients infected were older than 50 years of age and were not involved in a structured vaccination program as they aged (2).

Alarming as his editorial proved, little has changed since publication. Nearly 50% of all patients older than 50 years of age lack immunity to tetanus (3). Only 53.8% of persons age 50 to 64 years and 39.6% of persons older than age 65 years reported receiving tetanus toxoid during the previous 10 years compared with 65.2% among those age 18 to 49 years (4).

Sex, racial, and socioeconomic factors influence tetanus vac-

nation administration; men and white persons are more likely to receive the toxoid (1). Seventeen percent more men have protective levels of antibody to tetanus, and this disparity grows wider in persons older than age 70 years (5). Persons at or above the poverty level are more likely than persons below the poverty level to report receipt of the vaccine (1).

We are gatekeepers for an aging population with complex medical problems. The timing and acuity of office visits often preclude attention to immunizations as part of health maintenance. A thorough, structured office strategy involving physicians, nurses, and staff is vital to improving outcomes. Further vigilance is required to prevent "inexcusable" tetanus infections.

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CORRECTION

Correction: Successful Treatment of Refractory Sarcoidosis-Associated Uveitis with Infiximab

In a recent letter to the editor (1), the title was incorrect. Instead of "Successful Treatment of Sarcoidosis," it should have been "Successful Treatment of Refractory Sarcoidosis-Associated Uveitis with Infiximab."

Reference

1. Ali Y, Perlman E. Successful treatment of sarcoidosis [Letter]. *Ann Intern Med.* 2004;140:W70. [PMID: 15172930]

Pathogenesis of Hypertension

TO THE EDITOR: In the comprehensive and detailed review “Pathogenesis of Hypertension” by Oparil and colleagues (1), I was surprised by the repeated use of the term *essential hypertension*. I am probably only one of too many physicians who have incorrectly assumed for too many years that “essential” meant idiopathic. But, of course, it does not. Essential means necessary, and the term *essential hypertension* is an oxymoron. Blood pressure is what is essential, not hypertension.

However, truly egregious is our continued use of the term *benign* to modify “hypertension,” essential or otherwise, as required by the American Medical Association and the International Classification of Diseases, Ninth Revision (ICD-9), coding manual. The Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure has spent the past 35 years trying to teach the medical profession and the public alike that hypertension is anything but benign, yet we knowingly or unknowingly use

the diagnosis *benign hypertension* almost daily as a billing code (ICD-9 code 401.1).

It is time for our profession to abandon the terms *essential* and *benign* when discussing, diagnosing, or coding hypertension. It is time to think of hypertension pathophysiologically, as Oparil and colleagues so thoroughly described it. It is time to say what we mean.

Although all hypertension is, in truth, secondary, until we know the cause or pathogenesis in a given patient, *primary hypertension*, as advocated by Kaplan (2), would be the most appropriate term to use.

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