Letters to the Editor

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Best Treatment Approaches for Carpal Tunnel Syndrome

Original Article: Carpal Tunnel Syndrome

Issue Date: April 15, 2011

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TO THE EDITOR: Thank you for this review on carpal tunnel syndrome. However, several points in this article regarding splinting are potentially misleading. First, the authors assert that "there is good evidence supporting the use of neutral and cock-up wrist splints, with similar symptom relief outcomes with both styles." Although neutral and cock-up splints have been shown to relieve symptoms of carpal tunnel syndrome, two studies directly comparing neutral and cock-up splints showed superior improvement with neutral position splints.[1,2] Because neutral and cock-up splints are commercially available and similarly priced, family physicians should prescribe the best available product: the neutral position splint.

Second, the review states that "there is good evidence supporting the use of splints 24 hours a day (full-time) over night-only use." However, the referenced study showed improvement only in nerve conduction study results, a disease-oriented outcome.[3] There were no differences in clinical symptoms or functional status between the 24-hours-a-day and night-only groups. In fact, patients in the night-only group reported a much higher functional status than those in the 24-hour-a-day group. The study has other important limitations, including a small cohort size consisting mostly of men (carpal tunnel syndrome has a strong female predilection) who exhibited significant issues with brace-wear compliance. Although 85 to 100 percent of patients studied were compliant with night-only bracing, only 27 percent were even moderately compliant with 24-hour wear. This confirms our own experience that most patients will not wear splints 24 hours a day despite our best urging. We conclude that the best available patient-oriented evidence actually supports recommending night-only splint use, rather than wearing splints for 24 hours a day.

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IN REPLY: We would like to thank Drs. Beutler and Stephens for their thoughtful letter. A primary goal of our article was to highlight the effectiveness of splints and to advocate their use for the conservative management of carpal tunnel syndrome. Through experience, we have found that physicians and patients tend to use the splint that is most available to them at the time. Both cock-up and neutral wrist splints have been shown to be effective for symptom relief. We appreciate the clarification that neutral position splints do indeed show some statistical superiority over cock-up splints when measuring symptom relief, and should be used when available.[1] However, it is reasonable to use a cock-up splint if it is the one available to the physician and patient.

Regarding night-only versus 24-hours-a-day splint use, we highlighted end points,

namely sensory distal latency, that have noted improvement when splints are worn beyond the nighttime period. This being said, all other end points were similar between the two groups.[2] Therefore, recommendations for splint use beyond the nighttime period should be made on an individual basis, taking into account the patient's motivation, symptom severity, and tolerance of the splint.

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Counseling Women on Options for Management of Early Pregnancy Loss

Original Article: Office Management of Early Pregnancy Loss

Issue Date: July 1, 2011

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TO THE EDITOR: Thank you to Drs. Prine and MacNaughton for a well-written review of the management of early pregnancy loss. However, I felt their description of manual vacuum aspiration was incomplete. I regularly perform this office procedure, and it is a dilation and curettage, the same as any elective abortion, with the same risks and pain. It is not to be compared with an endometrial biopsy. In the accompanying patient information handout, the statement about the paracervical block numbing the pain inaccurately implies that the procedure is pain-free. The cervix is usually softened because of the loss, and the procedure usually takes less than five minutes; however, women who elect manual vacuum aspiration in an office setting should realize that this procedure may involve considerable discomfort, even when conscious sedation is being administered. Women who may be unable to tolerate the discomfort of a dilation and curettage should consider other options, including undergoing the same procedure in an operating room.

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IN REPLY: We appreciate Dr. Kaufman's concerns regarding the anticipatory guidance that women receive about the treatment for a miscarriage. Extensive literature exists on the pain associated with the first-trimester aspiration procedure.[1,2] Many authors conclude that the psychological state of the woman has the greatest influence on her perception of pain. As we point out in our article, patient preference about treatment choice is paramount. The article focuses on strategies that an office-based family physician can offer for management of miscarriage. However, after receiving accurate counseling regarding all aspects of the procedure (including logistics, timing, pain control, and cost), if the patient prefers a hospital-based procedure to expectant or medical management, or an office-based procedure, her preference should be honored.

We find that with this counseling nearly all women elect to stay within the family medicine office because this allows them to have a support person of their choosing with them throughout the procedure, and provides them the comfort and convenience of remaining in a familiar setting with a known physician. These benefits, in addition to other pain management modalities (including oral pain medications, the paracervical block, heat, music, and verbal anesthesia) allow women to cope exceptionally well with the discomfort of the procedure.

In the article, we noted that the procedure steps are similar to those of an endometrial biopsy, although a paracervical block is indicated and dilation of the cervix may be needed. This explanation of the required preparation and instruments is for physicians who may not perform the procedure.

During counseling, most women ask about the discomfort they will experience. The answer is that every option, including a procedure under general anesthesia, has its associated discomforts. Women should be counseled on all options and, ideally, be allowed to decide based on their preference rather than on availability of services.

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Conventional vs. Liquid-Based Cytology Pap Smears for Diagnosing Trichomoniasis

Original Article: Vaginitis: Diagnosis and Treatment

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TO THE EDITOR: Drs. Hainer and Gibson provided an excellent review of the assessment and treatment of vaginal discharge in symptomatic patients. However, we disagree with the statement that treatment of trichomoniasis "should not be based on a Papanicolaou (Pap) smear finding of trichomonads." On the contrary, recent research supports the practice of treating all trichomoniasis infections diagnosed on Pap smears.

A 2003 study demonstrated a specificity of 99.4 percent and a sensitivity of 61.4 percent for the diagnosis of trichomoniasis, using liquid-based cytology Pap smears.[1] This article concludes, "The presence of *[Trichomonas] vaginalis* organisms, as stated by the liquid-based Pap smear pathology report, is accurate and warrants treatment without further testing." A similar 2009 study of liquid-based cytology for *T. vaginalis* found a 98 percent sensitivity (95% confidence interval [CI], 94 to 100 percent) and a 96 percent specificity (95% CI, 94 to 98 percent).[2] The authors also recommend treatment for trichomoniasis when organisms are detected in a Pap smear.

Because this sexually transmitted infection may be a surprise finding for physicians and patients, counseling needs to be sensitive to the social needs of the patient. Physicians should also offer testing for additional sexually transmitted infections in patients with trichomoniasis detected on a Pap smear.

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IN REPLY: Drs. Wadhwa and Stanford raise the important question of the reliability of diagnosing trichomoniasis using Papanicolaou (Pap) smear cervical cytology. A meta-analysis of the performance of the Pap smear in the diagnosis of trichomoniasis found that assuming a prevalence of 20 percent, with a likelihood ratio for a positive Pap smear of 19, the probability that a woman with a positive test has trichomoniasis (the positive predictive value) is 83 percent.[1] The studies cited by Wadhwa and Stanford to support treatment of trichomoniasis diagnosed on Pap smears were conducted at a government referral center for sexually transmitted infections in Hong Kong, where the prevalence of trichomoniasis by culture was 22 percent,[2] and at an urban women's health center in Cleveland, Ohio, where the prevalence of trichomoniasis by culture was 21.6 percent.[3]

In primary care settings, however, the prevalence of trichomoniasis in patients with symptomatic vaginitis ranges from 6 to 17 percent. Using a prevalence of 10 percent, the positive predictive value for a positive Pap smear is 68 percent. At a prevalence of 1 percent, trichomoniasis has a positive predictive value of only 16 percent. Therefore, the conventional Pap smear does not appear to be a useful tool in the diagnosis of *Trichomonas vaginalis* in most primary care settings. However, liquid-based cytology appears to be more reliable.[4,5]

The Centers for Disease Control and Prevention's *Sexually Transmitted Diseases Treatment Guidelines, 2010* concludes: "While the sensitivity of a Pap test for *T. vaginalis* diagnosis is poor, use of a liquid-based testing has demonstrated enhanced sensitivity; however, false-positive tests can occur, and confirmatory testing might be needed in some circumstances."[6]

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