Letters to the Editor

Send letters to afplet@aafp.org, or 11400 Tomahawk Creek Pkwy., Leawood, KS 66211-2680. Include your complete address, e-mail address, and telephone number. Letters should be fewer than 400 words and limited to six references, one table or figure, and three authors.

Letters submitted for publication in *AFP* must not be submitted to any other publication. Possible conflicts of interest must be disclosed at time of submission. Submission of a letter will be construed as granting the AAFP permission to publish the letter in any of its publications in any form. The editors may edit letters to meet style and space requirements.

This series is coordinated by Kenny Lin, MD, MPH, Associate Deputy Editor for *AFP* Online.

Importance of Careful Corneal Inspection Prior to Fluorescein Examination

Original Article: Evaluation of the Painful Eye

Issue Date: June 15, 2016

See additional reader comments at: http://www.aafp.org/afp/2016/0615/p991.html

TO THE EDITOR: Pflipsen and colleagues provide an excellent review of the primary care approach to patients with eye pain. They include a useful algorithm to guide the diagnostic evaluation in *Figure 2*, but I would suggest a slight modification. The premature inclusion of fluorescein staining in the initial diagnostic step may hamper the differentiation of corneal abrasion from corneal ulcer, which has implications for subsequent management.

Most evaluation protocols for suspected corneal pathology include slit lamp examination,[1] but this is not readily available in many community primary care settings. Careful inspection of the cornea with good lighting and the aid of an ophthalmoscope or otoscope before applying the fluorescein will often reveal the gray infiltrate that helps distinguish an ulcer from an abrasion. This finding supports urgent ophthalmology referral as opposed to a more conservative approach for a suspected abrasion. Once the fluorescein has been placed, the uptake patterns for an abrasion and an ulcer are often similar, and the inflammatory infiltrate is obscured by the dye. A prospective review of a large number of corneal ulcers indicates a positive correlation between severe ulcers with virulent organisms, such as pseudomonas, and ulcer size at presentation,[2] suggesting that the most clinically important ulcers are more likely to be detectable by careful inspection at the initial visit.

Patients with eye pain and foreign body sensation often present initially to family physicians. Most of these patients have a self-limited abrasion that will resolve with conservative management. Appropriate care and efficient use of medical resources hinge on an accurate diagnosis. Careful initial inspection of the cornea for evidence of an ulcer before fluorescein application can facilitate clinical decision making in these cases.

JEFF WOLFREY, MD
Phoenix, Ariz.
E-mail: jeff.wolfrey@bannerhealth.com

Author disclosure: No relevant financial affiliations.

REFERENCES

1. Garg P, Rao GN. Corneal ulcer: diagnosis and management. *Community Eye Health*. 1999;12(30):21-23.
2. Mascarenhas M, Srinivasan M, Chen M, et al. Differentiation of etiologic agents of bacterial keratitis from presentation characteristics. *Int Ophthalmol*. 2012;32(6):531-538.

Interpreting the Statistics on Potential Benefits of Prostate Cancer Screening

Original Article: Top 20 Research Studies of 2015 for Primary Care Physicians

Issue Date: May 1, 2016

See additional reader comments at: http://www.aafp.org/afp/2016/0501/p756.html

TO THE EDITOR: I was disturbed by the conclusions made in this article concerning prostate cancer screening. *The Lancet* study[1] cited was chosen as one of the 251 studies that "had the potential to change practice if valid," and as one of the top 20 studies "judged to have the greatest clinical relevance for family physicians."

Let's suppose that the data from this study are valid. The clinical question posed is, "Are men who are invited to receive systematic prostate cancer screening better off than men who receive routine care?" The bottom-line answer provided is that "One would have to screen approximately 800 men to prevent one from dying of prostate cancer." I do not believe that this supports the authors' conclusion that "prostate cancer screening

provides a very small benefit, which is outweighed by significant potential harms of screening and associated follow-up treatment."

This conclusion will no doubt impact the decision making of many practicing physicians, but there is a danger of impersonalization inherent in reaching conclusions based solely on statistical data.

For another perspective, imagine sitting in a crowded football stadium with 100,000 men in the stands who have all been screened for prostate cancer. At halftime, all men whose lives were saved in the past 12 months because of prostate cancer screening are invited to come onto the field. According to the statistics derived from *The Lancet* study, there are now 125 men (100,000/800) enjoying a football game who would have been dead without screening. How many of the other men in the crowd would conclude that screening is only of little benefit and be inclined to forgo future screening for themselves? I hope family physicians reject practice-changing conclusions based only on "valid data" that ignore the value of individual lives lost because of nifty statistical analysis.

KEN JONES, MD
Christiansburg, Va.
E-mail: drkjones01@aol.com

Author disclosure: No relevant financial affiliations.

REFERENCE

1. Schröder FH, Hugosson J, Roobol MJ, et al.; ERSPC Investigators. Screening and prostate cancer mortality: results of the European Randomised Study of Screening for Prostate Cancer (ERSPC) at 13 years of follow-up. *Lancet*. 2014;384(9959):2027-2035.

IN REPLY: First, it is important to point out that we did not choose the top 20 research studies for our report; they were selected by thousands of members of the Canadian Medical Association who vote on the impact that each study has on their practice.

Second, Dr. Jones focuses entirely on the potential benefits of prostate cancer screening at the population level and disregards the harms. This is inappropriate, because when we are beginning with a population of asymptomatic men, it is particularly important that the process of screening, biopsy, and treatment does not do more harm than good. Unfortunately, the potential harms of screening for prostate cancer are well established. Based on data summarized by the Canadian Task Force on Preventive Health Care,[1] those 125 men would be joined on the field by more than 10,000 men who undergo treatment for prostate cancer, of whom about one-third never would have experienced symptoms or illness from the disease. Of those men, approximately 1,700 will experience urinary incontinence, 2,800 will experience long-term erectile dysfunction, and 40 to 50 will die from complications of prostate cancer treatment. These harms may be partially mitigated if more men opt for active surveillance or watchful waiting, although it is unclear to what extent.

Finally, we are not aware of any organization that recommends population screening for prostate cancer in all men in a certain age range. The American Urological Association[2] and the American College of Physicians[3] recommend that physicians discuss the potential benefits and harms of screening in men 55 to 69 years of age, but they do not recommend screening for all men in that age range. The Canadian Task Force[1] and the U.S. Preventive Services Task Force[4] recommend against screening for prostate cancer.

MARK EBELL, MD, MS
Athens, Ga.

ROLAND GRAD, MD, MSc
Montreal, Quebec, Canada
E-mail: roland.grad@mcgill.ca

Author disclosure: Dr. Grad has no relevant financial affiliations. Dr. Ebell is cofounder and editor-in-chief of Essential Evidence Plus, published by Wiley-Blackwell, Inc.

EDITOR'S NOTE: Dr. Ebell was a member of the U.S. Preventive Services Task Force from 2012 to 2015. The above communication represents his personal views and not those of the Task Force. Dr. Grad is currently a member of the Canadian Task Force on Preventive Health Care.

REFERENCES

1. Canadian Task Force on Preventive Health Care. Prostate cancer—harms and benefits. http://canadiantaskforce.ca/guidelines/published-guidelines/prostate-cancer/. Accessed December 2, 2016.
2. Carter HB, Albertsen PC, Barry MJ, et al.; American Urological Association. Early detection of prostate cancer: AUA guideline. April 2013. https://www.auanet.org/common/pdf/education/clinical-guidance/Prostate-Cancer-Detection.pdf. Accessed November 22, 2016.
3. Qaseem A, Barry MJ, Denberg TD, Owens DK, Shekelle P. Screening for prostate cancer: a guidance statement from the Clinical Guidelines Committee of the American College of Physicians. *Ann Intern Med*. 2013;158(10):761-769.
4. U.S. Preventive Services Task Force. Prostate cancer: screening. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening. Accessed December 2, 2016.

Conversations About Vaccines Should Underscore Their Public Health Benefits to Patients

Original Article: Strategies for Addressing and Overcoming Vaccine Hesitancy [Editorial]

Issue Date: July 15, 2016

See additional reader comments at: http://www.aafp.org/afp/2016/0715/p94.html

TO THE EDITOR: In their otherwise excellent editorial "Strategies for Addressing and Overcoming Vaccine Hesitancy,"

Drs. Loehr and Savoy write, "In the United States, the parent or patient has the right to make medical decisions…." Vaccination is a public health intervention, however, and not simply a medical one. Parents are required by law to immunize their children in order to send them to school, and as the editorial points out, the American Academy of Family Physicians opposes policies that allow nonmedical immunization exemptions. In the United States, we respect a person's right to travel freely; but, this does not mean we condone the running of red traffic lights, because doing so puts others at risk. This is precisely the point with immunization. A parent's refusal to vaccinate his or her child puts every other child at risk.

The public health rationale for vaccination and the community responsibility to have one's children vaccinated are critical messages that physicians for too long have failed to deliver to parents. In doing so, we have inadvertently contributed to a public failure to fully understand the rationale for recommending vaccines.

ANTHONY L. SCHLAFF, MD, MPH
Boston, Mass.
E-mail: anthony.schlaff@tufts.edu

Author disclosure: No relevant financial affiliations.

Corrections

Incorrect figure legend. The article "Community-Acquired Pneumonia in Adults: Diagnosis and Management" (November 1, 2016, p. 698) incorrectly identified the location of the infiltrate shown in the chest radiograph in *Figure 1* (p. 700). The figure legend should have read: "Chest radiograph showing right upper lobe infiltrate in a patient with pneumonia." The online version of the article has been corrected.

Scores listed in incorrect order. The article "Common Questions About Streptococcal Pharyngitis" (July 1, 2016, p. 24) contained an error in *Figure 1* (p. 25) that listed the scores of the clinical decision rule for diagnosing group A beta-hemolytic streptococcal (GABHS) pharyngitis in the incorrect order. This error occurred during the layout of the figure. The scores should have been listed in the following order (from left to right) with the respective percentage risk of GABHS pharyngitis: Score ≤ 0 (1% to 2.5%); Score = 1 (5% to 10%); Score = 2 (11% to 17%); Score = 3 (28% to 35%); Score ≥ 4 (51% to 53%). The online version of the article has been corrected and *Figure 1* is reprinted below. ■

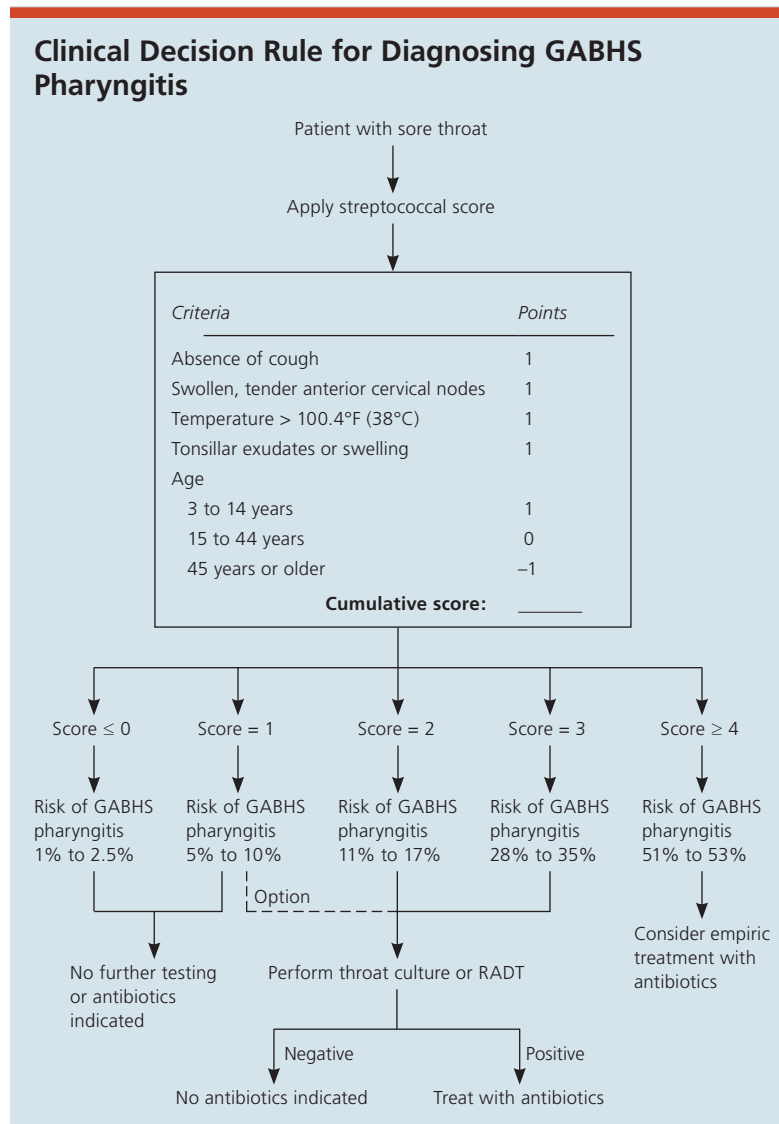

Figure 1. Modified Centor clinical decision rule for diagnosing GABHS pharyngitis. (GABHS = group A beta-hemolytic streptococcal; RADT = rapid antigen detection testing.)

Adapted with permission from Choby BA. Diagnosis and treatment of streptococcal pharyngitis [published correction appears in Am Fam Physician. *2013;88(4):222].* Am Fam Physician. *2009;79(5):385, with additional information from reference 18.*