

Letters to the Editor

Intimate Partner Violence During the COVID-19 Pandemic

To the Editor: The coronavirus disease 2019 (COVID-19) pandemic is exacerbating domestic violence in the United States. The term domestic abuse encompasses different forms of abuse, including intimate partner violence (IPV). In the United States, one in four women and one in 10 men experience some form of IPV.¹ These rates are expected to increase in response to social distancing measures because survivors are isolated with their perpetrator for longer periods of time. In March, U.S. police departments reported an increase in domestic violence calls as high as 27% after stay-at-home orders were implemented.² We are writing to offer suggestions on how family physicians can mitigate this urgent issue during telemedicine visits.

1. Screen every patient for IPV. The U.S. Preventive Services Task Force recommends screening all women of childbearing age for IPV. There are limited data on screening for IPV in men.³ Examples of screening tools for IPV are available in a previous *American Family Physician* article.⁴ Dialogue should begin by asking if the patient feels safe and valued in their relationship.⁴ When video is available, physicians should recognize nonverbal indicators of abuse, such as avoidance of eye contact or suspicious injuries on the head, neck, or forearms. During telephone visits, physicians should be sensitive to the patient's tone of voice because minimizing injuries and seeming fearful or evasive are other indicators of abuse.

2. Prioritize the patient's privacy. Screen for IPV without the patient's partner or children present, and reassure patients of their confidentiality rights.⁴ Identify the preferred method of communication before the telemedicine visit. Confirm if the patient can speak privately and safely. Some perpetrators monitor personal

accounts, phone calls, or internet history.¹ Physicians should teach patients how to clear their internet and phone histories if requested.

3. Use alternative methods of communication if needed. If a patient cannot speak openly during a telemedicine visit, ask only yes or no questions. The STAT (Slapped, Threatened, and Throw) screening tool exclusively uses yes or no questions. Consider nonverbal modes of communication, such as messaging through the health system's electronic portal. Physicians can direct patients to a safe chat room of the National Domestic Violence Hotline at <https://thehotline.org>. Patients can also text "HOME" to 741741 to communicate directly with a trained counselor from the Crisis Text Line. If there is immediate danger, advise patients to call 911.

4. Refer patients who screen positive for IPV to community resources. Referral to community resources can reduce psychological harms from IPV.⁵ Physicians can search for local shelters at <https://www.domesticshelters.org>, for resources by state at <https://www.womenshealth.gov/relationships-and-safety/get-help/state-resources>, and for resources to use during COVID-19 at <https://www.futureswithoutviolence.org/get-updates-information-covid-19/>.

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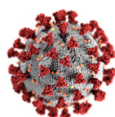
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2. Boserup B, McKenney M, Elkbulli A. Alarming trends in US domestic violence during the COVID-19 pandemic

Email letter submissions to afplet@aafp.org.

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. Letters may be edited to meet style and space requirements.

This series is coordinated by Kenny Lin, MD, MPH, deputy editor.



Coronavirus (COVID-19) Resources

Available at <https://www.aafp.org/afp/COVID-19.html>

[published online April 20, 2020]. *Am J Emerg Med*. Accessed June 30, 2020. [https://www.ajemjournal.com/article/S0735-6757\(20\)30307-7/pdf](https://www.ajemjournal.com/article/S0735-6757(20)30307-7/pdf)

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4. Dicola D, Spaar E. Intimate partner violence. *Am Fam Physician*. 2016;94(8):646-651. Accessed July 23, 2020. <https://www.aafp.org/afp/2016/1015/p646.html>
5. Krasnoff M, Moscati R. Domestic violence screening and referral can be effective. *Ann Emerg Med*. 2002;40(5):485-492.

Beware of the Differing Definitions for the False-Positive Rate

Original Article: Beware of False-Positive Results with SARS-CoV-2 Antibody Tests [Letter to the Editor]

Issue Date: July 1, 2020

Available at: <https://www.aafp.org/afp/2020/0701/p5a.html>

To the Editor: We read with interest the warning issued by Drs. Ebell and Barry regarding false-positive rates in antibody testing in their Letter to the Editor. We agree that testing in low-prevalence populations will result in a large number of false-positive test results. Because multiple definitions of the false-positive rate exist, it is important to state which definition is being used.¹

We are most familiar with the false-positive rate being defined as the complement of the specificity as in the evidence-based medicine glossary provided by *American Family Physician*.²⁻⁴ Using this definition, Table 1 from their letter, which “summarizes the false-positive rates at various population prevalence [levels],” does not make sense because specificity does not change with prevalence. The middle column of Table 1 lists a specificity of 96%; consequently, the false-positive rate should be 4% in all of the cells. The right column of Table 1 lists a specificity of 99%; consequently, the false-positive rate should be 1% in all of the cells. We agree that specificity may change based on other patient characteristics, and that patient characteristics may affect the estimate of the prevalence used in the calculations.

The definition of the false-positive rate used in Table 1 and in the text of their letter is the proportion of positive tests that are falsely positive, which in effect is the complement of the positive predictive value. Because the positive predictive value increases with the prevalence of the disease in the population, then, as shown in Table 1, the complement of the positive predictive value would decrease with the prevalence. We agree that this definition of a false-positive rate leads the reader to the relevant clinical question⁵; if the test result is positive, what is the probability that the disease is present?

Similar to the HIV epidemic, the severe acute respiratory syndrome coronavirus 2 that has caused the current pandemic has brought the diagnostic process to the forefront

of academic and lay discussions. We believe it is essential to recognize that the differing definitions of false-positive rate can have profound implications for public health and clinical decision-making.¹

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2. Sackett DL, Haynes RB, Tugwell P. *Clinical Epidemiology. A Basic Science for Clinical Medicine*. Little, Brown and Company; 1985.
3. Rothman KJ, Greenland S, Lash TL. *Modern Epidemiology*. 3rd ed. Lippincott Williams & Wilkins; 2014.
4. American Academy of Family Physicians. EBM glossaries. Accessed July 17, 2020. <https://www.aafp.org/journals/afp/authors/ebm-toolkit/glossary.html>
5. Stovitz SD. Confusion surrounding false-positive rates: distinguishing the definition from the important clinical question. *Curr Sports Med Rep*. 2014;13(2):69-70.

In Reply: Thank you for your thoughtful commentary on our research letter. We agree that the common use of the term false-positive rate is to describe the converse of specificity (i.e., one minus specificity). In the accompanying table, we list commonly used parameters for test accuracy.

The false-positive rate is commonly calculated as $B / (B + D)$, which Dr. Stovitz and colleagues point out is the converse of specificity. For example, in a receiver operating

TABLE

Calculating Parameters of Test Accuracy

	COVID-19 +	Not COVID-19 –
Serology +	A	B
Serology –	C	D
Sensitivity = $A / (A + C)$		
True-positive rate = $A / (A + C)$		
Specificity = $D / (B + D)$		
False-positive rate = $B / (B + D)$		
Positive predictive value = $A / (A + B)$		
Posttest probability of a positive test = $A / (A + B)$		
Negative predictive value = $D / (C + D)$		
Posttest probability of a negative test = $C / (C + D)$		

COVID-19 = coronavirus disease 2019.

characteristic curve, we plot the true-positive rate vs. false-positive rate. However, we were trying to communicate the likelihood of a false-positive test among all patients with a positive test. This is also a false-positive rate (actually, a ratio, but let's not quibble), just not the one commonly used in textbooks. There is no commonly used term for our false-positive rate, which is $B / (A + B)$, so we took the liberty of also calling it a "false-positive rate."

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Chronic Dyspnea

Original Article: Chronic Dyspnea: Diagnosis and Evaluation

Issue Date: May 1, 2020

See additional reader comments at: <https://www.aafp.org/aafp/2020/0501/p542.html>

To the Editor: As a family physician who had to retire from practice six years ago because of chronic hypoxia, I read with special interest the article on chronic dyspnea by Drs. Budhwar and Syed. When I became ill with cough, fatigue, and shortness of breath, my physician performed most of the workup the author describes. The diagnosis unfortunately remained unclear for many months until I checked my oxygen saturation while walking for three minutes in my office. I was shocked that my pulse oximetry reading was 78% with room air. It was later determined that I have an intrapulmonary shunt.

Although the article recommends checking oxygen saturation, I would humbly suggest that it also be evaluated with exertion if readings at rest are within normal limits, as mine had always been. Since my diagnosis, I have wondered how

many patients I might have been able to correctly diagnose as hypoxic by checking oxygen saturations with exertion.

Knowing the difference that oxygen therapy made in my life inspired this suggestion.

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Editor's Note: This letter was sent to the authors of "Chronic Dyspnea: Diagnosis and Evaluation," who declined to reply.

Corrections

Inaccurate statistic. In the Lown Right Care "Appropriate Use of Opioids for Chronic Pain," (September 15, 2020, p. 335), the second sentence of the Clinical Commentary section (page 335) incorrectly listed the number of people who died from opioid overdoses in 2017. The correct sentence should have read "In 2017, more than 70,000 people died from a drug overdose (47,600 involving opioids), making it the leading cause of injury-related death in people 25 to 64 years of age." The online version of this Lown Right Care has been corrected.

Incorrect listing of a state. In the Editorial "Closing Primary and Prenatal Care Gaps to Prevent Congenital Syphilis," (July 15, 2020, p. 78), the sixth sentence of the first paragraph (page 78) incorrectly listed Minnesota as a state that does not require screening for syphilis during pregnancy. Minnesota began requiring such testing in 2019. The correct sentence should have read "Iowa, Mississippi, New Hampshire, North Dakota, and Wisconsin do not require screening for syphilis during pregnancy, and third-trimester screening is optional in most states."⁶ The online version of this Editorial has been corrected. ■