

## Letters to the Editor

### Primary Palliative Care Starts Before End-of-Life

**To the Editor:** I enjoyed the article on end-of-life palliative care and appreciate its recognition of family physicians' place in palliative care.<sup>1</sup> However, I believe the language used in the title is potentially misleading and is a disservice to the role of family physicians in primary palliative care.

As the authors noted, there is a shortage of specialty palliative care clinicians worldwide. To ensure safe care for patients living with terminal illness, family physicians should be trained in primary palliative care.<sup>2</sup> The authors did an excellent job introducing palliative care, addressing symptom management for conditions frequently encountered in advanced illness, and guiding physicians in timing for a palliative care referral.

However, I recommend separating palliative care from end-of-life language whenever possible because language discordance has a negative impact on patient access to palliative and hospice care.<sup>3</sup> To empower family physicians to engage in primary palliative care, I believe we need to increase exposure to concepts of palliative care by acknowledging its role on the continuum of any diagnosis of advanced illness.

Adopting palliative care as a quality-of-life care model instead of a brink-of-death care plan helps increase concordance with palliative care as a part of any advanced illness treatment plan.<sup>4</sup> This type of linguistic alignment will help facilitate earlier engagement between patients and physicians, which leads to the benefits that come with earlier palliative care: increased quality of life, greater adoption of advance directives, and higher patient satisfaction.<sup>5,6</sup>

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**In Reply:** Thank you for your thoughtful comments on our article. We completely agree and support the need to separate palliative medicine from end-of-life terminology, especially in the setting of family physicians caring for seriously ill patients who need (and deserve) a skill set that includes excellent communication skills and anticipatory symptom management at all stages of life. Prevention of complications, symptom management in the context of life-prolonging therapies, and keen recognition of physical or emotional changes in the early stages of illness *before* end-of-life are paramount in the care family physicians provide to seriously ill patients.

Our purpose in the article was to summarize common symptoms in the context of specific organ failure and cancer settings and to highlight the parallels between primary and palliative

care (frequently provided by the same family physician). We could not agree more on the need to continue to learn, teach, and demonstrate the ongoing role of family physicians in delivering and facilitating better care of our patients long before the end becomes the present but were limited by scope and word count.

Again, we thank you for your support, attention, thoughtfulness, great references, and valid comments.

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### A1C Treatment Targets Considered in Clinical Context

**To the Editor:** The recent Lown Right Care article appropriately cautions against aggressive treatment to achieve A1C targets below 7% in older adults with diabetes.<sup>1</sup> I suggest an additional step: clinicians should critically evaluate whether an elevated A1C reflects true dysglycemia before making a diagnosis or initiating treatment.

A1C is influenced not only by glycemia but also erythrocyte lifespan and interindividual variation in glycation rates, both of which can alter A1C independent of average blood glucose levels.<sup>2-4</sup> In patients with a low pretest probability of hyperglycemia, these factors can produce misleading A1C elevations.

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I encountered an athletic 75-year-old woman with an A1C of 6% who was labeled as having prediabetes. Although this value technically fell within the American Diabetes Association range for prediabetes, the association acknowledges that A1C is unreliable as a diagnostic tool when erythrocyte dynamics or glycation rates are altered, urges diagnostic caution in such circumstances, and recommends using plasma glucose criteria instead.<sup>4</sup> Her fasting glucose was 88 mg/dL (4.9 mmol/L).

Additional pertinent findings included a triglyceride level of 50 mg/dL (0.56 mmol/L), high-density lipoprotein cholesterol level of 95 mg/dL (2.46 mmol/L) with a triglyceride to high-density lipoprotein ratio of 0.5, waist circumference of 27 inches (69 cm), body mass index of 20.6 kg/m<sup>2</sup>, and blood pressure of 118/60 mm Hg. This phenotype reflects high insulin sensitivity, with an exceptionally favorable triglyceride to high-density lipoprotein ratio, and is inconsistent with metabolic syndrome, pathologic dysglycemia, or insulin resistance.<sup>5,6</sup>

The patient's borderline-high hematocrit level of 45.2% and low-normal red cell distribution width of 12.2% were consistent with longer erythrocyte lifespan, a known contributor to misleadingly elevated A1C.<sup>2-4</sup> Despite these findings and her normal body mass index, she had been advised to lose weight and that pharmacotherapy, including insulin, might be required. In older adults with normal body mass index, weight loss may increase the risk of osteopenia, sarcopenia, frailty, and falls, whereas glucose-lowering therapy (especially insulin) carries well-established risks without demonstrated patient-oriented benefit at this level of glycemia.<sup>1</sup> This cascade—nonindicated testing, misinterpretation, overdiagnosis, and potential overtreatment—is preventable.

When interpreting A1C, as with any laboratory test, the entire clinical context should be considered. When a result is discordant with the clinical picture, a false-positive result should be considered before assigning a diagnosis with its attendant anxiety, diagnostic cascades, and potential harms.

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Editor's Note: This letter was sent to the authors of "Intensive Glucose Control in Older Patients With Diabetes," who declined to reply.

## Nonoperative Interventions for Achilles Pathology

**To the Editor:** I read with interest the recent article on heel pain.<sup>1</sup> It provides a helpful overview for family physicians; however, I would like to offer clarification regarding nonoperative management options for Achilles tendon pathology, particularly injection and biologic therapies.

The article states that for patients with compromised wound-healing capabilities, nonoperative options such as corticosteroid injections, platelet-rich plasma, extracorporeal shock wave therapy, radiofrequency microtenotomy, and biologic membranes are recommended.<sup>1</sup> Although these interventions may be considered in select cases in sports medicine, the cited evidence does not support their routine use, and they are not typically used in primary care.

A randomized controlled trial that compared nonoperative functional rehabilitation with open and minimally invasive surgical repair for acute Achilles tendon rupture found no meaningful differences in patient-reported or functional outcomes at 12 months. Importantly, this study did not evaluate injection or biologic therapies; therefore, their inclusion as nonoperative treatment options is not supported.<sup>2</sup>

Similarly, a Cochrane review of platelet-rich therapies for musculoskeletal soft tissue injuries concluded that the evidence is very low quality and insufficient to support their use, including for Achilles tendinopathy and rupture.<sup>3</sup> Achilles tendon-specific analyses were limited to one small randomized trial for tendinopathy and one for surgical augmentation, and neither demonstrated clinically meaningful benefit.<sup>3</sup>

Another Cochrane review of injection therapies for Achilles tendinopathy found no clinically relevant improvement in function at short-, medium-, or long-term follow-up and concluded that evidence is insufficient to support their routine use. Notably, one trial reported Achilles tendon rupture following corticosteroid injection.<sup>4</sup>

Presenting these advanced interventions as recommended nonoperative options may unintentionally overstate the strength of evidence and their applicability in primary care. Emphasizing progressive tendon-loading programs, activity modification, and appropriate referral better aligns with current evidence and the scope of family medicine practice.

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**In Reply:** On behalf of myself and my coauthors, I thank Dr. Wojda for the careful, meticulous appraisal of the evidence we summarized. In our article, we aimed to present recommendations that are feasible in primary care settings while acknowledging emerging therapies that may shape future clinical decision-making.

As Dr. Wojda notes, management of Achilles tendon pathology should be individualized through shared decision-making, with transparent discussion of the strengths and limitations of the supporting literature. We agree that no intervention should be portrayed as more effective than the evidence demonstrates.

Our grouping of nonsurgical interventions in the Achilles tendon rupture section, rather than delineating the evidence for specific Achilles pathologies, may be interpreted as insufficiently granular. For example, an approach most consistent with the literature should specify that high-volume injections (normal saline with local anesthetic, with or without a corticosteroid), particularly when performed with ultrasound guidance, have demonstrated short- to medium-term improvement in pain and function in some patients with Achilles tendinopathy.<sup>5</sup>

It may be helpful to frame the current therapeutic landscape as comprising options with variable quality of evidence and durability of benefit. These include topical nitroglycerin, heel lifts, structured physical therapy, progressive high-load strength training, short-term immobilization when indicated, extracorporeal shock wave therapy, bipolar radiofrequency microtenotomy, judicious use of corticosteroid injection in select cases, and pain psychology. These treatments may offer symptomatic relief over differing durations, and selection should reflect patient goals, comorbidities, and clinician expertise.<sup>6-10</sup>

Although platelet-rich plasma and micronized dehydrated human amnion/chorion membrane have generated substantial clinical interest, current evidence remains inconclusive. This reinforces the need for well-designed comparative trials with standardized reporting of outcomes.

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## Correction

**Incorrect test information.** "Colorectal Cancer Screening and Prevention" (September 2025, p. 278) incorrectly described details related to the US Food and Drug Administration's approval of a blood-based colorectal cancer screening test (Shield), inclusion of the test in national screening guidelines, and its screening interval. It was approved by the US Food and Drug Administration as a screening option for adults at average risk of colorectal cancer. Neither the US Preventive Services Task Force nor the American College of Gastroenterology currently recommends the test. Its optimal screening interval has yet to be established. The online version of the article has been corrected. ■