Letters to the Editor

Send letters to Kenneth W. Lin, MD, Associate Medical Editor for *AFP* Online, e-mail: afplet@aafp.org, or 11400 Tomahawk Creek Pkwy., Leawood, KS 66211-2680.

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Additional Screenings in the Adult Well Male Examination

Original Article: The Adult Well Male Examination

Issue Date: May 15, 2012

Available at: http://www.aafp.org/afp/2012/0515/p964.html

TO THE EDITOR: This review of the adult well male examination discussed the prevention of cardiovascular disease, but did not mention screening of the heart itself. Shouldn't family physicians be looking for occult or asymptomatic conditions, such as ventricular hypertrophy, ischemic disease, valvular malformations, dysrhythmias, and prolonged QT interval? Please provide guidance about which populations should be screened with electrocardiography, chest radiography, echocardiography, or other studies to detect cardiovascular diseases before they become symptomatic.

Similarly, there was no discussion of the importance of vision examinations in older men to diagnose conditions such as glaucoma, cataracts, macular degeneration, and corneal dystrophy, which would require referral to an ophthalmologist.

ALFRED PEARSON, MD
San Diego, Calif.
E-mail: pearbiker@aol.com

Author disclosure: No relevant financial affiliations to disclose.

IN REPLY: The U.S. Preventive Services Task Force (USPSTF) found insufficient evidence to support screening for ventricular hypertrophy and ischemic heart disease using electrocardiography[1] or nontraditional risk factors such as coronary artery calcification score.[2] Neither the USPSTF guidelines nor any other evidence-based guideline suggests screening for valvular disease, dysrhythmias, and prolongation of the QT interval in asymptomatic patients.

The American Heart Association estimates the theoretical cost of mass cardiovascular screening in athletes to be $2 billion per year, with a cost of $330,000 to detect a single case of relevant cardiac disease.[3] If one in 10 athletes with asymptomatic cardiac disease is at increased risk for sudden death without treatment, then the cost of preventing each theoretical death would be $3.4 million.[3]

Regarding whether to routinely screen older men for glaucoma, cataracts, macular degeneration, and corneal dystrophy, the USPSTF states that current evidence is insufficient to assess the balance of benefits and harms of screening for visual impairment in older adults.[4] Based on expert consensus, the American Academy of Ophthalmology recommends a comprehensive medical eye examination for all asymptomatic adults without risk factors for medical eye disease; screening should occur every five to 10 years in patients younger than 40 years, every two to four years in those 40 to 54 years of age, every one to three years in those 55 to 64 years of age, and every one to two years in those 65 years and older.[5]

JOEL J. HEIDELBAUGH, MD, FAAFP, FACG
Ann Arbor, Mich.
E-mail: jheidel@umich.edu

Author disclosure: No relevant financial affiliations to disclose.

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Letters

Screening Tests for Parasites in Refugees

Original Article: Primary Care for Refugees

Issue Date: February 15, 2011

Available at: http://www.aafp.org/afp/2011/0215/p429.html

TO THE EDITOR: The article on primary care for refugees by Dr. Eckstein lists recommended infectious disease screening and diagnostic tests for refugees. For nine of the 10 parasites listed in *Table 5*, the recommended screening test is "Three stool ova and parasites tests, collected on three different mornings." However, the Centers for Disease Control and Prevention (CDC) Guidelines for Evaluation of Refugees for Intestinal and Tissue-Invasive Parasitic Infections During Domestic Medical Examination, which were updated in 2010, clearly recommend a different approach.[1] The CDC guidelines recognize that the epidemiology of intestinal parasites varies worldwide, and that implementation of the recommended presumptive predeparture treatment varies by location. Therefore, the CDC's recommended strategy uses three distinct algorithms based on whether the refugee received predeparture treatment, and with what medication regimen. Specifically, the algorithms rely more on a complete blood count with differential, and less on serial stool ova and parasites testing, than the older sources cited in the article.

JEREMY SCHWARTZ, MD

New Haven, Conn.
E-mail: jeremy.schwartz@yale.edu

Author disclosure: No relevant financial affiliations to disclose.

REFERENCE

1. Centers for Disease Control and Prevention. Domestic intestinal parasite guidelines. http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/intestinal-parasites-domestic.html. Accessed February 13, 2012.

IN REPLY: The algorithms to which Dr. Schwartz refers are intended for use during the initial domestic medical examination for all refugees. These examinations and their associated screening algorithms are used by health care professionals specifically selected to perform that initial medical examination, and do not apply to primary care physicians seeing refugees as part of their regular patient panel. *Table 5* was meant to serve as a reference for primary care physicians in their regular settings (i.e., not part of the initial domestic medical examination) when refugee patients are symptomatic and an infectious cause is in the differential.

BARBARA ECKSTEIN, MD, MPH

Tucson, Ariz.
E-mail: eckstein@email.arizona.edu

Table 5. Recommended Infectious Disease Screening and Diagnostic Tests for Refugees

Infectious agent	*Test*	*Comments*
Parasites*†		
Ascaris lumbricoides (roundworm) *Entamoeba histolytica* Filariasis *Giardia lamblia* Hookworm *Taenia* species (tapeworm) *Trichuris trichiura* (whipworm)	Complete blood count with differential Three stool ova and parasites tests, collected on three different mornings	—
Plasmodium species	Complete blood count with differential Three thick and thin blood smears done over six to 12 hours, preferably during a fever spike	Consider in refugees from malaria-endemic areas with fever, thrombocytopenia, splenomegaly, or anemia
Schistosoma species	Complete blood count with differential, anti-*Schistosoma* antibody testing Three stool ova and parasites tests, collected on three different mornings	Consider in refugees from sub-Saharan Africa, especially if hematuria is present; infection is risk factor for bladder cancer
Strongyloides species	Complete blood count with differential, anti-*Strongyloides* antibody testing Three stool ova and parasites tests, collected on three different mornings	Untreated strongyloidiasis puts patients at risk of disseminated strongyloidiasis if they become immunocompromised
Sexually transmitted infections		
Gonorrhea/chlamydia	Urine or cervical gonorrhea/chlamydia	—
Hepatitis B	Hepatitis B core antibody, hepatitis B surface antibody, hepatitis B surface antigen	Screen all refugees coming from areas in which hepatitis B is endemic
HIV	HIV-1 and HIV-2	—
Syphilis	Rapid plasma reagin, VDRL	All refugees 15 years and older should be screened for syphilis
Other		
Helicobacter pylori	Fecal antigen preferable over serology[20]	—
Tuberculosis	Purified protein derivative/Mantoux test, Quantiferon-G, chest radiography	All refugees should be screened for tuberculosis because it is one of the most common infectious diseases in refugees[3]; consider renal tuberculosis in patients with hematuria

HIV = human immunodeficiency virus; VDRL = Venereal Disease Research Laboratories.

**—Suspect parasites with eosinophilia.*

†—*Negative stool sample results do not always rule out parasitic infections; therefore, serologic testing for antibodies may be necessary.*

Information from references 3, 19, and 20.

Author disclosure: No relevant financial affiliations to disclose.

EDITORS' NOTE: We appreciate Dr. Schwartz's letter and Dr. Eckstein's response on recommended screening and diagnostic tests for infectious diseases in refugees. The online version of *Table 5* has been revised to reflect that, in symptomatic patients, there is also a role for selected serologic tests (e.g., complete blood count that may indicate eosinophilia) in addition to stool testing for ova and parasites.

KENNETH W. LIN, MD
Associate Deputy Editor for *AFP* Online

JAY SIWEK, MD
Editor ■