Letters to the Editor

Screening and Immunizations for Refugees to the United States

Original Article: Primary Care for Refugees: Challenges and Opportunities

Issue Date: July 15, 2017

Available online at: https://www.aafp.org/afp/2017/0715/p112.html

To the Editor: We would like to thank Drs. Mishori, Aleinikoff, and Davis for reviewing the challenges and opportunities for refugees seen in primary care settings. We agree that refugees often face barriers to care as a result of cultural, language, and socioeconomic factors. We would respectfully like to provide clarification on a few points mentioned in the article.

The article states that the pre-resettlement examination is performed overseas, following technical guidelines from the Centers for Disease Control and Prevention with oversight from the U.S. State Department and the International Organization for Migration. It also states that documentation from this examination is available to state and local health departments through the National Notifiable Diseases Surveillance System (http://www.cdc.gov/nndss/nedss.html). In fact, documentation from the overseas medical examination is provided to state and local health officials through the Electronic Disease Notification system (https://www.cdc.gov/immigrantrefugeehealth/Electronic-Disease-Notification-System.html). This is a web-based system that notifies state or local health officials when all refugees (regardless of examination findings) and immigrants who are at risk of tuberculosis arrive in their jurisdictions.[1] Furthermore, panel physicians with the International Organization for Migration conduct examinations in many countries and manage resettlement logistics, but they do not provide oversight for the medical examination.

Table 3 states that hepatitis B screening should be performed for refugees from countries with greater than 2% prevalence. However, guidelines specify a prevalence rate of 2% or greater. It should be noted that most eligible refugees receive predeparture treatment for soil-transmitted helminths, schistosomiasis, *Strongyloides*, and malaria before arrival in the United States.[2]

Lastly, in Table 3, the action column for immunizations recommends that physicians order varicella zoster virus (VZV) immunoglobulin G (IgG) and hepatitis B surface antibody tests before vaccinating. We believe the authors meant that it is reasonable to check VZV IgG before administering the VZV vaccine. A positive VZV IgG result indicates previous infection, so the vaccination is not needed. We would agree with this approach. However, we were confused by the suggestion to check hepatitis B surface antibody test results before vaccinating. Most refugees are checked for hepatitis B infection before departure by screening for hepatitis B surface antigen. When that test result is negative, the vaccine series is initiated overseas. If testing has not been performed previously, it should be done after arrival, regardless of the vaccine history (as indicated by the authors). The hepatitis B surface antibody test can be used to indicate immunity by vaccination, but only in a completely immunized person. On its own, in a partially vaccinated or unvaccinated person, it is not particularly helpful. A positive hepatitis B surface antibody test result with a negative anti–hepatitis B core antibody result must be interpreted with caution in a recently or partially immunized person.[3]

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This series is coordinated by Kenny Lin, MD, MPH, Deputy Editor.

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Editor's Note: This letter was sent to the authors of "Primary Care for Refugees: Challenges and Opportunities," who declined to reply.

Consider Atlanto-Occipital Joint Dysfunction as a Cause of Secondary Otalgia

Original Article: Ear Pain: Diagnosing Common and Uncommon Causes

Issue Date: January 1, 2018

See additional reader comments at: https://www.aafp.org/afp/2018/0101/p20.html

To the Editor: This comprehensive review indicates that temporal mandibular joint syndrome is a common cause of secondary otalgia. Another cause not mentioned in the article is atlanto-occipital joint dysfunction. Tenderness and restricted range of motion at this joint in a patient with otalgia suggests that atlanto-occipital joint dysfunction could be the cause. Treatment with osteopathic manipulative therapy can provide prompt relief of symptoms.[1]

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Editor's Note: This letter was sent to the authors of "Ear Pain: Diagnosing Common and Uncommon Causes," who declined to reply.

The Many Potential Causes of Sudden Cardiac Death in Young Athletes

Original Article: Hypertrophic Cardiomyopathy: An Often Silent Disorder with Delayed Diagnosis [Close-ups]

Issue Date: December 1, 2017

See additional reader comments at: https://www.aafp.org/afp/2017/1201/p738.html

To The Editor: I believe that the statement in this Close-ups that the death of college basketball player Hank Gathers was the result of hypertrophic cardiomyopathy is an oft repeated error that highlights the problem with using contemporary media, particularly Wikipedia, as a source. His death did indeed involve a form of cardiomyopathy, but it is believed myocarditis was the cause, not hypertrophic cardiomyopathy.[1] Although hypertrophic cardiomyopathy is a common cause of sudden death in athletes, it was specifically excluded as the cause of death for Hank Gathers. It has even been speculated that had Gathers withdrawn from competition for a substantial period and fully recovered from myocarditis, he might have safely resumed competition.

Sadly, many young athletes have died of undiagnosed hypertrophic cardiomyopathy. However, Gathers's death serves as a reminder that there are many other potential causes of sudden cardiac death in young athletes, including myocarditis, right ventricular dysplasia, and anomalous coronary arteries.

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