Letters to the Editor

Top 20 POEMs Should Provide Better Context of Study Quality and Scope

Original Article: Top 20 Research Studies of 2017 for Primary Care Physicians

Issue Date: May 1, 2018

See additional reader comments at: https://www.aafp.org/afp/2018/0501/p581.html

To the Editor: Drs. Ebell and Grad have provided an excellent summary of patient-oriented evidence in their article and should be commended for their efforts to concisely update busy family physicians. As physicians, we agree with many of the practice recommendations and encourage all physicians to read the article as a starting point for discussions and reflections on their own best practices.

A review of publications to inform patient care requires consideration of the quality and scope of the study and previous studies on the same topic. Overlooking problems with study quality can create overconfidence in study results. Overestimating the scope of the study may lead to incorrect generalizations beyond the study topic. Not placing the study in context of previous studies risks overweighing spurious results that may run counter to a larger body of equal-quality or superior-quality evidence. We are concerned that in the presentation of clinical questions and bottom-line answers for "Cardiovascular Disease and Hypertension," some of these considerations are missing.

Study 1, an investigation on blood pressure measurements using a bare arm vs. a shirt sleeve, is presented with the clinical question, "What is the best way to measure blood pressure?"[1] This question is beyond the scope of the actual article. A more accurate clinical question, such as "How accurate is measuring blood pressure with clothing compared to bare arm?" would help reduce the risk of incorrect generalization by readers.

Study 2 raises concerns of study quality and missing background information.[2] This is a nonrandomized observational evaluation of automated 30-minute office blood pressure (OBP30) measurements. Although the results of the study are impressive, the study authors noted several limitations, including a lack of comparison arm, lack of randomization, and potential bias from regression to the mean. Stating the study results without providing context of the study quality could make readers overconfident about the effectiveness of the OBP30 compared with the superior-quality evidence of other ambulatory or automated methods of office blood pressure measurement. A bottom-line answer reflective of the study quality and the background of previous studies might include, "This study was limited by lack of randomization or control, and further study would be of benefit before comparing OBP30 with other validated methods such as ambulatory blood pressure monitoring."

We hope raising these concerns will better inform readers and highlight some of the challenges in critical appraisal.

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2. Bos MJ, Buis S. Thirty-minute office blood pressure monitoring in primary care. *Ann Fam Med.* 2017;15(2):120-123.

In Reply: Thank you for your comments. We fully agree that interpretation of individual studies requires a careful evaluation of study quality and a sense of where it fits in the large body of research. As a group, we have written nearly 5,000 POEMs (patient-oriented evidence that matters) over the past 20 years and recognize that any critical appraisal must balance completeness and context with clarity and conciseness. Each published POEM has separate sections that describe the "Study design," "Population studied," "Funding source," "Allocation concealment" (for randomized controlled trials), and a 200- to 300-word "Synopsis" that provides an objective assessment of the context, results, and any biases. Readers can read the full POEMs summaries of the top 20 research articles here: https://www.aafp.org/afp/poems2017.

However, the article summarizing the top 20 research articles of 2017 as determined by Canadian physicians ▶

included only an edited "Clinical question" and "Bottom line". The other sections were necessarily omitted given space constraints. For the POEM about study 1, the original POEM title was "Bare Arm Best for BP Measurement" and would have been read before the clinical question.

Regarding the second study, the full POEM clearly highlighted potential limitations, including the statement that "It remains to be seen whether this result occurs in other settings or whether patient outcomes are improved", implying the need for a randomized trial. We suspect that this study was selected by Canadian Medical Association members as one of the most relevant studies of the year in light of the SPRINT study that used a similarly time-consuming approach to measuring blood pressure[1] and found that the mean of those six measurements was 23/12 mm Hg lower than the initial office blood pressure. The larger message that blood pressures measured after a period of rest in the office are lower than those taken immediately is an important one, and clinicians who choose to apply the SPRINT trial results in their practices should make sure to measure blood pressure the same way.

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Broadening the Female Athlete Triad: Relative Energy Deficiency in Sport

Original Article: The Female Athlete Triad: Recommendations for Management [Editorial]

Issue Date: April 15, 2018

See additional reader comments at: https://www.aafp.org/afp/2018/0415/p499.html

To the Editor: We thank Dr. Chamberlain for a thorough editorial on the management of the female athlete triad. In 2014, the International Olympic Committee (IOC) published a consensus statement encouraging a broader approach to the female athlete triad.[1] The IOC introduced the more comprehensive term relative energy deficiency in sport to describe a syndrome in which low energy availability can lead to multiple medical problems in men and women.[2]

In relative energy deficiency in sport, an athlete's dietary energy intake is insufficient to support his or her energy expenditure.[3] Cyclists, rowers, runners, jockeys, and athletes in weight class combat sports (e.g., wrestling, boxing) are particularly susceptible.[4] The uncoupling of energy availability with energy expenditure negatively affects not only the skeletal and endocrine systems, but also the cardiovascular, renal, gastrointestinal, reproductive, and central nervous systems.[5]

The IOC has developed a clinical assessment tool (available at http://bjsm.bmj.com/content/bjsports/early/2015/04/17/bjsports-2015-094873.full.pdf) for primary care clinicians to help diagnose relative energy deficiency in sport, as well as guide decisions on return to play.[6] There is still much to learn about this condition. Family physicians have a key role in recognizing and preventing this syndrome by educating athletes, their families, coaches, school administrators, and communities about proper nutrition and healthy athletic participation.

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The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Army, Department of the Air Force, Department of Defense, or the U.S. government.

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In Reply: Thank you for your thoughtful letter regarding this editorial. My goal was to draw attention to a disorder that family physicians are well positioned to identify and treat and to have a significant impact on the health of the athlete. You are right to highlight that female athlete triad is part of a broader disorder: relative energy deficiency in

sport, which can affect male and female athletes' health and performance. Family physicians can be instrumental in identification and treatment of this disorder.

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Case Report: Gonorrhea as a Cause of Exudative Tonsillitis

To the Editor: An 18-year-old female presented to clinic with three days of painful, swollen tonsils in the setting of recurrent tonsillitis. She reported ear pain with swallowing, but no fevers, dysphagia, or cough. She visited urgent care two months prior for the same complaint and was treated for streptococcal pharyngitis despite a negative rapid strep test. She reported four to five episodes of tonsillitis each year. A comprehensive sexual history revealed the patient engaged in penile-oral sex.

Physical examination was notable for edematous tonsils with white exudate and tender submental lymphadenopathy. She was afebrile, and there was no erythema of the pharynx. Rapid strep testing was negative, but an additional tonsillar swab returned positive for gonorrhea. The patient's urine was also positive for gonorrhea, but screening for HIV, chlamydia, and trichomoniasis was negative. The patient was informed of the results and returned to clinic for intramuscular ceftriaxone (Rocephin) and was prescribed azithromycin (Zithromax).

Gonorrhea is the second most common reportable disease in the United States behind only chlamydia.[1-3] The number of reported cases of gonorrhea has risen steadily since a historic low in 2009, an increase of 48.6% from 2009 to 2016.[3] Adolescents and young adults 15 to 29 years of age account for most new cases.[2,3] Although gonococcal tonsillitis is a well-described infection, diagnosis requires taking a sexual history.[4] Although sometimes asymptomatic, gonococcal tonsillitis presents with sore throat in 64% of cases. Fever and cervical lymphadenopathy are much less common.[1,2,4] In one review, 20.6% of gonococcal tonsillitis presented with whitish-yellow exudate.[4]

Diagnosis of gonococcal tonsillitis requires a positive culture from the pharynx.[1] A sexual history is essential in guiding the decision to test, and an appropriate sexual history includes not only identifying high-risk behaviors, but also the sites of sexual contact.[2] Penile-oral contact is the single highest risk factor for gonococcal tonsillitis.[1,2,4]

Treatment should include intramuscular ceftriaxone plus doxycycline or azithromycin to prevent resistance and also because co-infection rates of chlamydia are as high as 20% to 54%.[1,2] Treatment also entails counseling the patient on appropriate condom use for all sexual contact, treatment of partners, and avoidance of all sexual contact until treatment has been completed and symptoms have resolved.[1,2]

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Corrections

Incorrect CME Quiz Answer. The CME Quiz (July 1, 2018, p. 18) listed an incorrect answer choice for Quiz Question #4 in the "Answers to This Issue's CME Quiz" box on the inside back cover. The correct answer listed for Quiz Question #4 from the article "Allergy Testing: Common Questions and Answers" (p. 34) should have been "D. Persons 17 years or older with systemic cutaneous reactions." The online version of the quiz has been corrected.

Article Title Change. The Photo Quiz, "Eye Changes After Recent International Travel" (December 15, 2017, p. 807), contained an error in the title. In the clinical scenario description, the patient reports his symptoms began after returning from a trip to Puerto Rico. The title of this article inadvertently referred to this as international travel, which is not the case when traveling from the United States. The title should have been "Eye Changes After Recent Travel." The online version of the article has been corrected.

Vitamin K Antagonists. The Practice Guideline, "Newly Detected Atrial Fibrillation: AAFP Updates Guidelines on Pharmacologic Management" (September 1, 2017, p. 332), incorrectly identified vitamin K antagonists as vitamin K agonists in the first paragraph in the left column on page 333. The sentence should have read: "Vitamin K antagonists are the first-line option, with high-quality data indicating that they have a lower stroke risk and all-cause mortality vs. placebo." The online version of the article has been corrected. ■