

Letters to the Editor

Low Specificity Limits Use of Test for Spondylolysis in Children and Adolescents

Original Article: Back Pain in Children and Adolescents

Issue Date: July 1, 2020

See additional reader comments at: <https://www.aafp.org/afp/2020/0701/p19.html>

To the Editor: This article discusses the stork test to diagnose spondylolysis. However, this test is useless if not counterproductive because of its low specificity. Given that most children with low back pain do not have spondylolysis, most positive test results are false positives. It would be helpful if the authors provided the sensitivity and specificity for the other diagnostic maneuvers mentioned in the article.

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In Reply: We appreciate the feedback about physical examination maneuvers that are used to diagnose spondylolysis. The use of the stork test is somewhat controversial because of the low specificity (17% to 32%) cited in our article. We are currently working with two groups that are evaluating approaches to better diagnose spondylolysis because radiography is also insensitive. New techniques in magnetic resonance imaging that improve bone visualization can be helpful.¹ Although spondylolysis is common, family physicians need an improved understanding of methods to diagnose and treat this condition, which limits the ability of many adolescents to participate in sports.

In response to physical examination testing for specific conditions, other common maneuvers may have limited clinical evidence. For example, absent bowel sounds have classically been associated with small bowel obstruction but have poor sensitivity (32%) and positive predictive value (23%).^{2,3} We agree that limitations of physical examination testing should be discussed and that these tests should be evaluated through additional research.

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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.

Author disclosure: No relevant financial affiliations.

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Blood Transfusion Decisions in Adults with Nonvariceal Upper Gastrointestinal Bleeding

Original Article: Upper Gastrointestinal Bleeding in Adults: Evaluation and Management

Issue Date: March 1, 2020

Available at: <https://www.aafp.org/afp/2020/0301/p294.html>

To the Editor: The article by Dr. Wilkins and colleagues comprehensively addressed this important topic. However, the section on blood transfusions is not consistent with the latest guidelines and does not address some important considerations. The article states that the threshold for blood transfusion should be 7 g per dL (70 g per L) unless there is ischemic heart disease, recent cardiac surgery, or hematologic malignancies (in which case the threshold is 8 g per dL [80 g per L]) based on the 2010 International Consensus Recommendations on the Management of Patients with Nonvariceal Upper Gastrointestinal Bleeding.¹ However, a 2019 update of the guideline recommends a threshold of 8 g per dL for all patients.² In addition, the guideline goes on to note that “the threshold recommendation does not apply to patients with exsanguinating bleeding. In the setting of acute blood loss, hemoglobin values may initially remain unchanged from baseline because of plasma equilibrium times. In such situations, transfusion should not be dictated by current hemoglobin level alone but should take into account the predicted drop in hemoglobin and the patient’s clinical status.”

In the two trials that comprise nearly all of the data supporting the 2019 recommendation, exsanguinating bleeding was either not defined³ or included patients with shock (a systolic blood pressure less than 100 mm Hg or pulse greater than 100 beats per minute) who were transfused within two hours of arrival in the emergency department.⁴ Even if the bleeding has stopped, equilibration will almost certainly bring the hemoglobin to less than 8 g per dL even before the effects of hemodilution with crystalloids, which would be necessary to try to

achieve hemodynamic stability. In such a situation, clinical judgment is critical, and in our view, opting to immediately transfuse such a patient is a reasonable choice. However, crystalloids should be started while waiting for the type and crossmatch to be done.

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In Reply: Thank you for your thoughtful response to our article. Our article referenced the 2010 consensus recommendations regarding transfusions in patients with non-variceal upper gastrointestinal bleeding.¹ We completed the final literature search for our article in November 2019. The 2010 consensus statement reports that the blood transfusion threshold should be 7 g per dL. The transfusion threshold is 8 g per dL in patients with ischemic heart disease, recent cardiac surgery, or hematologic malignancies. Drs. Ehrlich and Trow's letter to the editor referenced the consensus guidelines published in December 2019.² The 2019 consensus statement reports the new transfusion threshold of 8 g per dL for all patients. We agree with Drs. Ehrlich and Trow that the hemoglobin may lag in patients with ongoing and life-threatening upper gastrointestinal bleeding. Transfusion decisions in these situations must be individualized based on comorbidities, rate of bleeding, and clinical judgment.

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Newborn Circumcision Techniques and Medical Ethics

Original Article: Newborn Circumcision Techniques

Issue Date: June 1, 2020

See additional reader comments at: <https://www.aafp.org/afp/2020/0601/p680.html>

To the Editor: The article by Dr. Omole and colleagues describes common techniques for performing newborn circumcision. Although the technical discussion is sound, other sections of the article do not reflect the current literature.

The authors cite health benefits from circumcision, such as reduced risk of urinary tract infections (UTIs), penile cancer, phimosis, and HIV infection. However, these risks need context. UTIs are virtually always treatable and are relatively uncommon in boys regardless of circumcision status. The cited report suggests that the number of circumcisions needed to prevent one (likely treatable) UTI is approximately 100. Penile cancer is one of the rarest malignancies for which site-specific data are available in the United States.¹ Pathologic phimosis usually can be treated nonsurgically with a steroid cream.² The data on HIV infection come from studies of voluntary adult circumcision in sub-Saharan Africa where there is an epidemic of heterosexually transmitted HIV; the relevance of these data to newborn circumcision in the United States has not been established.¹

The risk of loss of the penile prepuce from circumcision is 100%.³ If this genital structure has any value, then its removal is a harm, whatever the (further) risk of surgical complications. The patient's inability to decide if his genitals should be permanently surgically altered is also a consideration. Circumcision removes anatomically normal, nondiseased, functional tissue—from a psychosexually significant part of the body—with no urgent medical need and without the consent of the patient.¹

Physicians should be aware of the rapidly changing ethical and legal landscapes for circumcision. A recent federal court case clarified that even a sterilized "ritual nick" to the vulva of a child or infant for religious reasons constitutes physical assault, which has implications for male circumcision.⁴ A group of more than 90 physicians, medical ethicists, legal scholars, and other experts argued that "cutting any person's genitals without their informed consent is a serious

violation of their right to bodily integrity [and is] morally impermissible unless the person is nonautonomous (incapable of consent) and the cutting is medically necessary.”²⁵

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In Reply: Thank you for your comments on our article. We applaud your work on genital mutilation, sexual assault, and medical ethics as they relate to what has been accepted in society. Unfortunately, we did not address the medical ethics of newborn circumcision in this article because of word count restrictions; therefore, we listed the adverse effects that have been commonly cited for the procedure. The medical ethics of newborn circumcision is a formidable topic in itself and would require an additional article on how religion and culture impact science. We welcome collaboration on this topic at a future HeLa Conference at Morehouse School of Medicine to discuss ethical dilemmas in medicine.

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Corrections

Updated recommendation. The article “Upper Gastrointestinal Bleeding in Adults: Evaluation and Management,” (March 1, 2020, p. 294) referenced a recommendation from

2010 regarding blood transfusions for patients with upper gastrointestinal (GI) bleeding when hemoglobin is less than 7 g per dL (70 g per L). During the publication process of this manuscript the recommendations were updated in December 2019, but these updates were not included in the article. The seventh sentence of the abstract (page 294) should have read: “A bolus of normal saline or lactated Ringer solution should be rapidly infused to correct hypovolemia and to maintain blood pressure, and blood should be transfused when hemoglobin is less than 8 g per dL.” The first sentence of the “Transfusions and Coagulopathy” section should have read: “Current guidelines recommend blood transfusion for patients with upper GI bleeding when hemoglobin is less than 8 g per dL (80 g per L), including patients with coronary artery disease, recent cardiac surgery, or hematologic malignancies.”²⁷ This update also required a change to question 6 from the March 1, 2020 CME Quiz (page 268). The question should have read: “A patient with upper GI bleeding from peptic ulcer disease is transferred to the hospital because he is hemodynamically unstable. Except for anticoagulation for deep venous thrombosis, he has no significant medical history. The patient’s international normalized ratio is 1.5 and his hemoglobin is 9 g per dL (90 g per L). Which one of the following recommendations is correct?” The correct answer choice is C as the answer choices were not affected.

Also, in the sixth sentence of the abstract and the first sentence of the second paragraph of the “Initial Evaluation and Stabilization” section, the laboratory test type and crossmatch was listed instead of type and screen. In both places, the sentence should have read: “Laboratory tests should include a complete blood count, basic metabolic panel, coagulation panel, liver tests, and type and screen.” The online version of this article and the March 1, 2020 CME Quiz have been corrected.

Inaccurate disease description. In the Practice Guidelines “Community-Acquired Pneumonia: Updated Recommendations from the ATS and IDSA” (July 15, 2020, p. 121), in the title of Table 2 (page 122) and the first sentence in the second paragraph of the Antibiotic Therapy section (page 124), the word severe was inadvertently included before community-acquired pneumonia. The title of Table 2 should have read: “Initial Treatment Regimens for Outpatients with Community-Acquired Pneumonia.” The sentence should have read: “Table 2 lists options for antibiotic regimens for the empiric treatment of CAP in the outpatient setting.” The online version of this Practice Guideline has been corrected. ■