Letters to the Editor

Automated Office Blood Pressure for Diagnosing Hypertension

To the Editor: The U.S. Preventive Services Task Force (USPSTF) recommendation statement on hypertension in adults reaffirmed the benefits of screening[1]; however, it missed an opportunity to promote automated office blood pressure (AOBP) measurements as an easier-to-implement alternative to ambulatory blood pressure monitoring (ABPM). The guideline states that AOBP is comparable to ABPM; however, the supporting evidence review discounted the literature on AOBP by stating, "there is substantial heterogeneity and it is unclear if lack of mean mm Hg differences would result in similar diagnostic categorization and treatment decisions."[2] The most recent and largest meta-analysis found that this heterogeneity is not clinically significant.[3]

The Agency for Healthcare Research and Quality evidence synthesis states, "…without analysis of test accuracy outcomes (e.g., sensitivity, specificity), it is not possible to conclude whether AOBP would result in similar clinical screening and diagnostic results as ABPM or [home blood pressure monitoring]."[4] This logic is flawed. If blood pressure is a continuous outcome related to cardiovascular risk, and AOBP is similar to ABPM, then it follows that the sensitivity and specificity of AOBP will be similar to that of ABPM. Mathematically, two measures cannot be so closely matched but have different sensitivities and specificities. The only difference will be for a threshold value for hypertension. For example, a person with an average systolic blood pressure of 140.2 mm Hg with one method could have a systolic blood pressure of 139.9 mm Hg with another method. However, there is no clinically significant difference in atherosclerotic cardiovascular disease risk between these two measurements. Multiple studies now recommend treating patients based on atherosclerotic cardiovascular disease risk[5]; therefore, the USPSTF should acknowledge the close correlation of AOBP and ABPM and recommend using the former.

Practicality also needs to be considered. It is logistically challenging to have patients submit multiple home blood pressure readings to diagnose hypertension. It is easier to implement a screening program with AOBP machines in the outpatient setting. Each clinic needs to purchase a device and screen each patient at the desired interval. If the USPSTF wants to optimize the detection of elevated blood pressure, it should recommend AOBP because it is easy to implement and closely resembles ABPM. The USPSTF cited only one randomized trial that reported improvements in clinically meaningful outcomes (i.e., hospitalization) from hypertension screening; this trial used AOBP for screening.[6]

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References

1. U.S. Preventive Services Task Force. Hypertension in adults: screening. Final recommendation statement. April 27, 2021. Accessed July 2, 2021. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertension-in-adults-screening
2. Guirguis-Blake JM, Evans CV, Webber EM, et al. Screening for hypertension in adults: updated evidence report and systematic review for the US Preventive Services Task Force. *JAMA*. 2021;325(16):1657-1669.
3. Roerecke M, Kaczorowski J, Myers MG. Comparing automated office blood pressure readings with other methods of blood pressure measurement for identifying patients with possible hypertension: a systematic review and meta-analysis. *JAMA Intern Med*. 2019;179(3):351-362.
4. Guirguis-Blake JM, Evans CV, Webber EM, et al. Screening for hypertension in adults: a systematic evidence review for the U.S. Preventive Services Task Force. (Prepared by Kaiser Permanente Research Affiliates Evidence-based Practice Center under contract no. HHSA-290-2015-000017-I-EPC5.) AHRQ publication no. 20-05265-EF-1. Agency for Healthcare Research and Quality; June 2020. Accessed July 2, 2021. https://www.uspreventiveservicestaskforce.org/uspstf/document/draft-evidence-review/hypertension-in-adults-screening
5. Blood Pressure Lowering Treatment Trialists' Collaboration. Pharmacological blood pressure lowering for primary and secondary prevention of cardiovascular disease across different levels of blood pressure: an individual participant-level data meta-analysis [published correction appears in *Lancet*. 2021;397(10288):1884]. *Lancet*. 2021;397(10285):1625-1636.

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This series is coordinated by Kenny Lin, MD, MPH, deputy editor.

6. Kaczorowski J, Chambers LW, Dolovich L, et al. Improving cardiovascular health at population level: 39 community cluster randomised trial of Cardiovascular Health Awareness Program (CHAP). *BMJ*. 2011;342:d442.

Editor's Note: See related Putting Prevention into Practice on page 193.

Community Alcoholics Anonymous Programs Are Not a Replacement for Formal Treatment

Original Article: Alcoholics Anonymous and Other 12-Step Facilitation Programs for Alcohol Use Disorder [Cochrane for Clinicians]

Issue Date: March 1, 2021

Available at: https://www.aafp.org/afp/2021/0301/p272.html

To the Editor: Global engagement in Alcoholics Anonymous (AA) is high, with several million members in 180 countries.[1] However, the effectiveness of AA has been difficult to study because of a lack of randomized controlled trials (RCTs). The RCTs have not reported a positive effect of AA; however, many cross-sectional and cohort studies have shown improved abstinence with engagement in AA compared with no engagement in 12-step facilitation programs.[2,3] The Cochrane review emphasized the positive findings of AA and 12-step program affiliation.[4] However, two details of the review should cause primary care physicians to hesitate before referring patients to AA as an alternative to traditional treatment for alcohol use disorder.

AA and other 12-step facilitation programs that produced higher rates of continuous abstinence over other established treatments in the Cochrane review were described as manualized, which was defined as following a session-to-session outline offering treatment based on "standardized content delivered in a linear or modular fashion to ensure that the same treatment is delivered across time and different sites".[5] Community AA programs would not be considered manualized because each group is autonomous.

Significantly positive results were related to the time abstinent from alcohol, continuous period of abstinence, and percentage of days abstinent. The most meaningful patient-oriented outcome examined is the negative impact of consequences of drinking, including physical, social, and psychological consequences. These consequences make up most of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. criteria for diagnosis of an alcohol use disorder, whereas percentage of time abstinent or length of continuous abstinence plays no role in diagnosing or determining the severity of alcohol use disorder. Unfortunately, none of the reviewed studies showed an advantage for AA or 12-step facilitation programs in reducing the negative consequences of drinking.[5]

Effective treatments for alcohol use disorder are medications and behavioral therapy. Although this review provides evidence that participation in AA or other 12-step programs may be helpful for people with alcohol use disorder who seek abstinence, the evidence is not compelling enough to consider community AA programs a replacement for formal treatment. Primary care physicians should include counseling on mutual aid groups (including AA) while developing a treatment plan with their patients. Physicians should feel comfortable discussing what to expect at meetings and the benefits of affiliation, and be aware of local mutual aid groups, including being able to provide contact information and meeting availability for patients who express interest.

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References

1. Alcoholics Anonymous. A. A. around the world. Accessed May 17, 2021. https://www.aa.org/pages/en_US/aa-around-the-world
2. Magura S, Cleland CM, Tonigan JS. Evaluating Alcoholics Anonymous's effect on drinking in Project MATCH using cross-lagged regression panel analysis. *J Stud Alcohol Drugs*. 2013;74(3):378-385.
3. McCrady BS. Recent research into twelve-step programs. In: Miller S. *The ASAM Principles of Addiction Medicine*. 6th ed. Wolters Kluwer Health; 2018:1084-1097.
4. Salisbury-Afshar E, Kauppila G. Alcoholics Anonymous and other 12-step facilitation programs for alcohol use disorder. *Am Fam Physician*. 2021;103(5):272-273. Accessed May 7, 2021. https://www.aafp.org/afp/2021/0301/p272.html
5. Kelly JF, Humphreys K, Ferri M. Alcoholics Anonymous and other 12-step programs for alcohol use disorder. *Cochrane Database Syst Rev*. 2020;(3):CD012880.

In Reply: Thank you for highlighting these important points. We generally agree with your interpretation of the findings of the Cochrane review. We were not suggesting that AA and 12-step facilitation programs should be recommended instead of licensed addiction treatment

services. However, many licensed addiction treatment programs in the United States use 12-step facilitation as a central component of their programming; therefore, the Cochrane review findings provide further support for this practice.

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Strangulation as a Cause of Dysphagia

Original Article: Dysphagia: Evaluation and Collaborative Management

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See additional reader comment at: https://www.aafp.org/afp/2021/0115/p97.html

To the Editor: Strangulation is an important cause of dysphagia and is relevant to family physicians. Strangulation involves applying pressure to the neck with the hands, a constricting band, or an arm. It can diminish cerebral blood flow or occlude the airway and result in carotid artery dissection, making it a potentially lethal act.[1] Strangulation is commonly associated with intimate partner violence (IPV), and women are at particularly high risk, with a documented sevenfold increased risk of death from homicide among women experiencing IPV-related strangulation.[2]

Survivors of strangulation report that when they sought medical attention, symptoms such as difficulty swallowing were often dismissed or incorrectly attributed to more common ailments. Because physicians cannot rely solely on visible findings to identify strangulation, dysphagia is an important presenting symptom. In addition to dysphagia, patients commonly experience neck pain, sore throat, voice changes, and neurologic manifestations.[3]

Physicians with a high index of suspicion for strangulation should screen patients appropriately. Survivors may not disclose their experience because of impaired memory, lack of knowledge regarding the seriousness and sequelae of strangulation, or unfamiliarity with the term strangulation.[4] Questions about strangulation should include terms more familiar to survivors, such as choked, blacked out, jacked-up, or choked-off.[5] Inquiry should also be made about a loss of consciousness.

Management varies based on the time of presentation and may involve additional imaging, including imaging of the carotid artery.[4] Recognizing dysphagia as a symptom of strangulation may also prevent unnecessary interventions, such as prescription of a proton pump inhibitor or invasive procedures.

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References

1. Matusz EC, Schaffer JT, Bachmeier BA, et al. Evaluation of nonfatal strangulation in alert adults. *Ann Emerg Med*. 2020;75(3):329-338.
2. Glass N, Laughon K, Campbell J, et al. Non-fatal strangulation is an important risk factor for homicide of women. *J Emerg Med*. 2008;35(3):329-335.
3. Training Institute on Strangulation Prevention. The investigation and prosecution of strangulation cases. 2013. Accessed March 19, 2021. https://www.strangulationtraininginstitute.com/wp-content/uploads/2015/07/California-Strangulation-Manual_web3.pdf
4. Jordan KS, Murphy JA, Romine AJ, et al. A case of nonfatal strangulation associated with intimate partner violence. *Adv Emerg Nurs J*. 2020;42(3):186-195.
5. Bergin A, Berkowitz R. Domestic violence in military families: non-fatal strangulation. *Md Med*. 2012;13(3): 19, 29.

In Reply: We appreciate the thoughtful comments of Drs. Giusti and Ravi and agree that strangulation should be included in the differential diagnosis of any patient, particularly younger women, presenting with dysphagia or hoarseness.

This is also a timely reminder that family physicians should routinely screen all women of reproductive age for IPV.[1] Although open-ended questions are the best way to begin a trusting dialogue,[2] we also agree with Drs. Giusti and Ravi that more directly focused questions are necessary when evaluating patients with new symptoms and with chronic, unexplained functional distress or pain.

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References

1. U.S. Preventive Services Task Force. Final recommendation statement. Intimate partner violence, elder abuse, and abuse of vulnerable adults: screening. October 23, 2018. Accessed May 11, 2021. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening
2. DiCola D, Spaar E. Intimate partner violence. *Am Fam Physician*. 2016;94(8):646-651. Accessed May 5, 2021. https://www.aafp.org/afp/2016/1015/p646.html

Case Report: Consequences of Misdiagnosed Anal Cancer

To the Editor: An 84-year-old patient with a history of tobacco use, diabetes mellitus, and hypertension presented to our office for shortness of breath and diarrhea. The patient had been experiencing fecal incontinence, pain with defecation, and bloody stools for the past three years. More recent symptoms included loss of appetite, weight loss, and fatigue. One year ago, the patient was diagnosed with hemorrhoids and prescribed a topical ointment for relief.

A physical examination was notable for a large perianal mass *(Figure 1)*. Laboratory findings included anemia, hematuria, proteinuria, and an elevated carcinoembryonic antigen level. Computed tomography of the pelvis showed enlarged right inguinal and left perirectal lymph nodes, rectal wall thickening with fat stranding, and potential invasion of the right levator ani muscle, causing suspicion for a locally advanced neoplasm. Computed tomography of the abdomen revealed a 1-cm nodular density in the liver that could be peritoneal metastasis. A biopsy showed an extensive high-grade squamous intraepithelial lesion with focal changes that may represent early microinvasion. The patient was diagnosed with squamous cell carcinoma of the anus and treated with surgical debulking of the anal mass, followed by chemotherapy and radiation therapy.

FIGURE 1

Large perianal mass.

Anal cancer is a rare malignancy with 9,090 new cases diagnosed annually in the United States and an increasing incidence of 2.7% per year.[1] In 2020, there were an estimated 1,350 deaths from anal cancer.[2] Most anal cancers are squamous cell carcinomas. The most common risk factor for developing anal squamous cell carcinoma is human papillomavirus infection. Additional risk factors include immunosuppression, a history of sexually transmitted infection, and tobacco use.[3]

Early symptoms of anal cancer can be difficult to distinguish from benign anorectal disorders such as hemorrhoids, condylomas, and anal fissures. In one study, primary care physicians misdiagnosed anal malignancies as hemorrhoids in 27% of first visits, delaying appropriate diagnosis and treatment.[4] To decrease delays, physicians should maintain a high index of suspicion with a low threshold to evaluate patients at risk for anal cancer. Efforts to prevent anal cancer should include universal human papillomavirus vaccination in childhood and education of patients at high risk.

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References

1. Ryan DMD, Willet CMD. Classification and epidemiology of anal cancer. UpToDate. Accessed March 1, 2021. https://www.uptodate.com/contents/classification-and-epidemiology-of-anal-cancer?search=anal+mass&source=search_result&selectedTitle=7~150&usage_type=default&display_rank=7
2. National Cancer Institute. Cancer stat facts: anal cancer. Accessed March 1, 2021. https://seer.cancer.gov/statfacts/html/anus.html
3. Eng C, Messick C, Glynne-Jones R. The management and prevention of anal squamous cell carcinoma. *Am Soc Clin Oncol Educ Book*. 2019;39:216-225.
4. Chiu S, Joseph K, Ghosh S, et al. Reasons for delays in diagnosis of anal cancer and the effect on patient satisfaction. *Can Fam Physician*. 2015;61(11):e509-e516. ■