

Letters to the Editor

The Importance of Inclusivity During the Spiritual Assessment

To the Editor: I read with interest the article by Dr. Kuckel and colleagues.¹ I understand and agree with the authors' stated intent that it is important that clinicians explore what beliefs give "patients a sense of greater purpose in life," whether through a connection with God or "nature, energy, art, music, and humankind."¹ However, I am concerned that in current colloquial discourse, the words they propose to assess these connections—spirituality and faith—are too closely tied to religious creed to be universally welcoming.

The words "meaning" or "meaningful" are not mentioned in their suggested approaches, as in "What gives you meaning in life?" Such words imply greater inclusivity and can, when responsive to patients' replies and respectful of their points of view, open the door to the questions the authors specifically endorse in their recommended assessment tools.

By focusing on spirituality and faith as informationally oriented objects of investigative attention, the authors also fail to highlight the therapeutic power that can result from encounters between clinicians and patients. This cocreation of shared presence has everything to do with the in-the-moment expression and valuation of human vulnerability, dignity, interdependence, resilience, and even transcendence—all characteristics of spirituality and faith, broadly considered—and may offer a worthy path to holistic healing and meaningful growth on both sides of the stethoscope.²⁻⁴

Editor's Note: This letter was sent to the authors of "The Spiritual Assessment," who declined to reply.

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

3. Ventres W, Dharamsi S. Beyond religion and spirituality: faith in the study and practice of medicine. *Perspect Biol Med*. 2013;56(3):352-361.
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Rapid Removal of a Bee Stinger

To the Editor: We want to correct the information presented in Table 6 about how to remove a bee stinger in the "Arthropod Bites and Stings" article.¹ The authors repeat the legend that a person should never squeeze the autotomized stinger embedded in the flesh because it can result in injection of additional venom into the sting site. However, no data supporting this common sense recommendation have been reported in the literature. In contrast, many reports have demonstrated that it is incorrect. In 1935, Snodgrass revealed the morphology of the honeybee sting apparatus. A stinger's valvular lobe on the first valvulae drives the venom through the sting shaft into the stung target.² When the venom reservoir is pinched, these lobes prevent the venom from passing through them into the sting shaft embedded in the skin. More than 20 years ago, our research groups independently published in medical journals that the primary consideration in removing honeybee stingers is time—the faster, the better.^{3,4} Venom delivery by the embedded stinger occurs rapidly after implantation, emptying the venom reservoir within 30 seconds. Scraping out the stinger with fingernails or pulling it out with fingers is faster than fumbling around to find a dull (knife) blade or credit card. By the time a person finds a credit card or blade, more venom will have been pumped into the wound than if the stinger had been immediately pulled or rubbed out.

The rapid removal of a bee stinger provides two advantages. It decreases the amount of venom pumped into the wound, thereby reducing the pain of the sting and, more importantly, decreasing the risk of a severe anaphylactic reaction. Anaphylaxis is dose dependent. The more a person can minimize the amount of venom injected, the greater probability of preventing a severe allergic reaction.⁵

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In Reply: We thank Dr. Schmidt and colleagues for their careful reading and interest in our article. We agree that evidence on the proper technique for removing Hymenoptera stingers is limited. The cited articles suggest that rapid removal (within five to 10 seconds) is an important consideration in minimizing envenomation^{1,2}; however, only the *Lancet* article directly investigated different removal techniques. In the *Lancet* study, two volunteers were stung multiple times on the forearm, with the stinger removal time and method (grasping vs. scraping) varied by researchers and the weal size measured. The authors concluded that there was not a statistically significant difference in weal size between

removal techniques; however, based on the limited study size and the high risk of bias, we believe the results of this study are more hypothesis generating than practice changing.¹

Until consistent, high-quality evidence to the contrary is available, we agree with recommendations from the American Academy of Dermatology and the National Institute for Occupational Safety and Health that patients should be advised to try and remove the stinger as rapidly as possible, with the preferred removal method being scraping or flicking (instead of squeezing with tweezers or fingers).^{3,4}

The opinions and assertions contained herein are the private views of the authors and are not to be construed as official or as reflecting the views of the U.S. Air Force or the U.S. Department of Defense.

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Case Report: Onychodystrophy From Late-Onset Congenital Malalignment of the Great Toenails

To the Editor: A healthy 18-year-old patient presented with three years of bilateral great toenail thickening, with no preceding trauma, tight footwear, or family history of skin or nail disease. Empiric treatment with topical antifungals had been ineffective.

The examination found subtle valgus deformities at the interphalangeal joints of both great toes, with hyperkeratosis, yellowing, horizontal ridging, and lateral nail plate deviation (Figure 1). The right nail plate showed early trapezoidal change at the distal edge (Figure 2). The patient's skin and other nails were unaffected.

Histology of the nail bed and matrix found no cytologic atypia or inflammation. Two negative fungal cultures of the nail plate excluded onychomycosis. Onychodystrophy from late-onset congenital malalignment of the great toenails was diagnosed.

Congenital malalignment of the great toenail is the lateral deviation of the nail plate on its longitudinal axis and is usually bilateral and present at birth.¹ Theories about its pathogenesis include nail matrix deviation because of increased traction by the extensor hallucis tendons and dysynchronous growth of the nail apparatus and the distal phalanx.^{1,2} Mechanical instability of the nail plate with poor contact between the nail plate and bed, combined with secondary trauma, hemorrhage, or bacterial infection, results in nail plate thickening, opacity, ridging, and tapering toward the distal edge.²

Congenital malalignment usually presents in early childhood, with a slight female predilection.² However, chronic microtrauma and

FIGURE 1



Subtle valgus deformities at the interphalangeal joints with hyperkeratosis, yellowing, horizontal ridging, and lateral nail plate deviation.

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recurrent mechanical stresses in a patient with an existing mild, initially clinically inapparent congenital malalignment may lead to the emergence of nail plate deviation later in life.³

Spontaneous resolution has been reported in one-half of childhood cases of congenital malalignment, but data on late-onset malalignment are limited.⁴ Clinicians should evaluate and treat secondary infections. Therapeutic considerations are the degree of nail plate deviation and patient preference. Well-fitting footwear,

FIGURE 2



Close-up of the right great toenail showing lateral nail plate deviation and early trapezoidal change at the distal edge.

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nail trimming, and a podiatry review would be reasonable recommendations for this patient because of their mild lateral deviation and preference for conservative treatment. Partial or total matricectomy may be considered when the deviation is notable or causes ingrown nails and pain. Surgical realignment of the nail apparatus has been described in children two years and younger.⁴

Recognizing nail plate malalignment in patients presenting with great toenail onychodystrophy helps to minimize unnecessary procedures and ineffective treatment and manage expectations about the trajectory of recovery.

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Case Report: Induced Lactation in an Adoptive Parent

To the Editor: Breastfeeding has many nutritional and psychological benefits, including the passage of SARS-CoV-2 antibodies in milk.^{1,2} Induced lactation is the initiation of lactation in a person who has not given birth and may interest some families, including couples who are adopting or same-sex couples (e.g., when both want to breastfeed after one carried the pregnancy).

Physicians can induce lactation by simulating the two stages of a biological pregnancy. In stage I, estrogen stimulates the development of mammary tissue, and progesterone inhibits milk production. By withdrawing these agents, physicians can simulate the hormonal changes of parturition, which causes estrogen levels to drop and the

breast to lose progesterone receptors, rendering the tissue responsive to prolactin.³

In stage II, prolactin and oxytocin, which establish and maintain the milk supply,^{4,5} are secreted when mechanoreceptors in the nipple and areola are stretched. Oxytocin is secreted when the patient sees or hears a baby. Prolactin stimulates lactogenesis by the mammary glands. Oxytocin stimulates the contraction of smooth muscle to expel milk, and mechanical nipple stimulation promotes the maternal secretion of these hormones.^{3,5} *Table 1* summarizes the main hormonal regulators of lactogenesis and excretion.

A healthy 27-year-old nulliparous woman asked their family physician for help inducing lactation before adopting an infant. In consultation with pharmacy services, a regimen was constructed with a low-androgenicity progestin and estrogen to imitate pregnancy.⁶ The patient was prescribed ethinyl estradiol/ethynodiol diacetate, 35 mcg/1 mg daily, to be discontinued 48 hours before initiating lactation.

After 23 weeks, the patient was matched with an infant. They discontinued ethinyl estradiol/ethynodiol diacetate and started taking 20 mg of domperidone (available in the United States only by physician request) four times daily, pumping every two to three hours. Domperidone is a dopamine antagonist that promotes the secretion of prolactin. Domperidone is preferred over metoclopramide because it does not cross the blood-brain barrier.^{1,6} The patient initially

TABLE 1

Main Hormonal Regulators of Lactogenesis and Excretion

Hormone	Origin in pregnancy	Function
Estrogen	Placenta	Stimulates the development of mammary tissue
Oxytocin	Neurohypophysis	Stimulates the contraction of smooth muscle to expel milk
Progesterone	Placenta	Inhibits milk production
Prolactin	Adenohypophysis	Stimulates lactogenesis by the mammary glands
Prolactin-inhibiting hormone	Placenta	Renders the breast unresponsive to prolactin

produced 17 oz of milk per day. After consulting with a lactation specialist, they produced 30 oz of milk per day.

This patient demonstrates how family physicians can support parents who have not given birth and want to breastfeed. Careful counsel and clinical judgment are necessary due to the lack of literature on this topic, but the benefits may justify the effort for some families. Blinded, placebo-controlled studies are needed to evaluate the safety and effectiveness of induced lactation.

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Alcohol Use Disorder Following Metabolic Surgery

To the Editor: Drs. Banerjee and colleagues provided a comprehensive review of metabolic surgery for adult obesity.¹ Although the authors included current alcohol use in the exclusion criteria, readers might benefit from knowing about the increased risk of alcohol use disorder following metabolic surgery. A formal mental health preoperative evaluation is recommended in patients with a known or suspected psychiatric illness or substance use disorder; however,

individuals may develop new unhealthy alcohol use or alcohol use disorder following metabolic surgery.² Among individuals without preoperative unhealthy alcohol use within two years of the procedure, metabolic surgery was significantly associated with the development of unhealthy alcohol use several years after metabolic surgery regardless of whether patients had laparoscopic sleeve gastrectomy or Roux-en-Y gastric bypass.³

Although the mechanism of increased alcohol use after metabolic surgery is not fully understood, Roux-en-Y gastric bypass may affect obesity-induced regulation of dopamine reward processing, increasing sensitivity to alternative rewards such as alcohol instead of food.⁴ Risk factors for alcohol use disorder following metabolic surgery include preoperative regular alcohol use, male sex, younger age, tobacco use, attention-deficit/hyperactivity disorder, and mental health disorders.^{5,6} These factors can help family physicians identify patients at high risk and provide counseling and close follow-up after metabolic surgery.

Editor's Note: This letter was sent to the authors of "Metabolic Surgery for Adult Obesity: Common Questions and Answers," who declined to reply.

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