

COMMENT & CONTROVERSY

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"It's time to retool the annual exam: Here's how,"
by Barbara S. Levy, MD (June)

The comprehensive physical exam is a dying art

Dr. Levy's article was excellent, and the public would be well served if her suggestions were incorporated into practice. However, I must comment on her point that a comprehensive exam has little screening value. I agree completely, but for a different reason: Few physicians have the skills to perform the type of exam that makes a difference.

They may put the stethoscope on the chest, but many physicians don't listen as they do so, and if they did, they wouldn't know what they were hearing. Very few ObGyns (or even younger family physicians and internists) know what to do with a tuning fork, or why we use a different one to assess neuropathy than we use for hearing deficit. They rarely look into eyes, and if they did, they would not recognize macular degeneration or cataracts. They do not know what a carotid bruit sounds like—or its significance. I could give many more examples.

There are numerous conditions that are either asymptomatic or develop so gradually that the patient is unaware when one is present. The past 35 years have proved to me that many of these conditions can be revealed through careful examination of an "asymptomatic" patient. I cannot count the many dozens of cases of skin cancer (they have their clothes off, why not look?), cataracts, macular degeneration, valvular heart disease, atrial fibrillation or atrial septal

defect (which can lead to stroke), early congestive heart failure, thyroid cancer, lymphoma, neuropathy, colon cancer, and many other conditions that I have discovered during a routine physical, often in healthy younger women just needing a refill or prenatal care. Most of these conditions would have been missed by the half-hearted and cursory poke and glance that now passes as the standard of care for a physical exam. When a patient is relatively asymptomatic, it is unlikely that a diagnostic test will be ordered, so only the careful history and physical will bring the condition to light.

That said, I am in agreement with Dr. Levy's recommendations. It is a new world, but I am not convinced that everything new represents progress.

David F. Coppin, MD
Logan, Utah

Keep screening for domestic violence

Although Dr. Levy's article contained many thoughtful points, I felt she inappropriately de-emphasized screening for domestic violence. In her outline, domestic violence screening is listed as "optional," along with screening for bladder health and thyroid disease. In the subsequent discussion of these optional items, she ignored domestic violence entirely but took time to point out that there is money to be made from screening for bladder health.

Universal screening for domestic violence with new patients, and annual



"Most of these conditions would have been missed by the half-hearted and cursory poke and glance that now passes as the standard of care for a physical exam"

or longitudinally across the constricted region and the two flaps that have been created from the Z are transposed. This maneuver releases constriction well.

When constriction extends distally, the procedure used is, basically, a reverse perineoplasty: Cut the constriction band longitudinally, undermine the vagina, and then sew it back transversely. This relieves the distal band.

In a severe case of vaginal constriction, thigh flaps that are left on their vascular pedicle can be brought into the vagina to fill the gap created by cutting through the constriction. Initial incisions are made laterally in the vagina (unilaterally or bilaterally, depending on the degree of constriction) and extended to the perineum/vulva. Measurements are made to determine the length and width

of flap(s) needed. The flaps are then mobilized, rotated into the defect(s), and sutured into place. This technique significantly increases the diameter of the vagina and can add length, if needed.

What about correcting shortening?

An iatrogenically shortened vagina presents the most challenging of cases. The vagina must be opened up at the cuff; ideally, this produces adequate length without having to enter the peritoneum. ■



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re-screening of those with a positive history or suggestive signs and symptoms, are standard of care for all primary care specialties, especially obstetrics and gynecology. Let us not turn back the clock to the days when we ignored this major health problem.

John P. Stewart, MD
Asheville, NC

Dr. Levy responds:

Focus was on the evidence

Dr. Coppin is certainly correct: An astute clinician can uncover significant conditions in asymptomatic patients at the time of routine screening. However, studies looking at outcomes in a population of screened versus unscreened patients for most of the interventions he discusses have not demonstrated any statistically significant improvement in health outcome in the screened population. For these large-scale studies to prove effectiveness, a condition would need to be prevalent in the population studied and easily discovered with the

screening intervention. As Dr. Coppin points out, the conditions he mentions may be quite challenging to diagnose with physical examination alone, and most are uncommon in the population we routinely see.

Nevertheless, the point of my article is that, indeed, there is value in an annual encounter with the patient. What each of us chooses to include in that encounter will vary, but Dr. Coppin and I are in agreement that screening should certainly encompass those evidence-based interventions discussed in the article. The addition of a careful and well-informed history and physical examination will at times add value to the standard protocols I described.

Dr. Stewart raises an important issue, which certainly deserves attention at every encounter with our patients—not just the annual well-woman examination—along with screening for substance abuse (especially alcohol), depression, and sexual dysfunction. These are areas in which Ob-Gyns have excelled.