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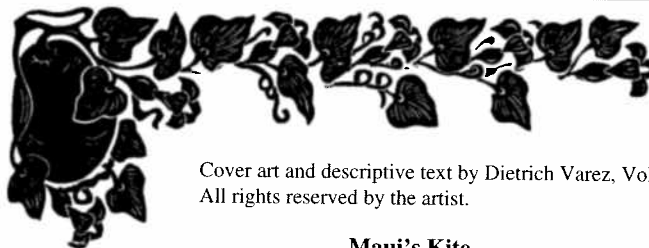

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Maui's Kite

Maui the demi-god enjoyed flying kites. A friend of *Maui's* had a special calabash that contained the winds. He would release them at will whenever *Maui* needed them to fly his kite.

Looking forward to reading and enjoying more issues of the *Hawaii Medical Journal*?

Hawaii is proud of its only peer-reviewed medical publication. The *Journal* will be publishing more informative, interesting, and innovative articles in future issues. We have two special issues coming up. The September issue will feature Domestic Violence and Women's Health and the November issue will be on Death with Dignity. You can ensure that your personal copy of the *Hawaii Medical Journal* arrives on your desk every month by subscribing today.

The subscription rate is $25 a full year. Please make check payable to Hawaii Medical Journal, 1360 S. Beretania Street, Second Floor, Honolulu, Hawaii 96814.

Editorial

Norman Goldstein MD

How to Become the Positively Perfect Physician

The article on page 98 first appeared in *The New Physician* in November 1986, and is reproduced with permission of the author, Catherine Lee, and *The New Physician*. It was appropriate and timely when it first appeared, and remains just as timely.

Catherine Lee is a prolific writer, having served as a reporter-feature writer for the *St Louis Globe-Democrat* and as a health education writer for the Hawaii State Department of Health, the East-West Center, and the John A. Burns School of Medicine.

She has had articles published in *American Way, Modern Maturity, The Rotarian, Learning, Medical Economics*, and other local national publications. During World War II, she served with the American Red Cross in U.S. Hospitals in Australia and New Guinea.

Many thanks, Catherine, for sharing your insights into the Positively Perfect Physician.

Letters to the Editor

Optometrists Threaten Public Safety with Bill

A.A. Smyser's April 2 article, "Letting optometrists write prescriptions," does a great disservice to the public. Smyser condones giving optometrists, who have never gone to medical school, the right to treat nearly every eye disease treatable with drugs by legislative fiat rather than with the necessary education and training.

The public needs to know the truth about this bill since Smyser obviously was not apprised of its contents.

It is not [for] legislation to let nonmedical eye doctors treat itchy eyes and pink eyes with a few over-the-counter drugs. Optometrists want to treat every major eye disease treatable with topically applied eye drugs, for a starter. The "simple" diseases they want to treat include glaucoma, corneal ulcers, iritis, and keratitis. These are major eye diseases.

The drugs they wish to use include every major drug now used by fully trained medical eye specialists, ophthalmologists. In other states with prescriptive authority, optometrists are now heavily lobbying their legislators to allow them to use oral and injectable medications, including narcotics, and to perform laser surgery on patients.

Optometrists have testified that they will not ask to prescribe oral medications or controlled substances this year. But they have indicated that they intend to ask for those privileges in the future. So much for sincerity and goodwill.

Calvin M. Miura, MD, President
Hawaii Ophthalmological Society
(*Honolulu Star-Bulletin*. April 6, 1996:B3)

President's Message

Carl W. Lehman MD

The Need to Live Right, the Right to Die

"Lucky we live Hawaii," most of us would agree. With the honor of having the longest life span in the nation comes the reality of meeting the demands of an aging society. When the baby boomers reach age 65, the impact on health care, housing, transportation, economic and social structures will be enormous. As physicians who see the anguish of patients and loved ones dealing with terminal illness and disabling conditions, we know the importance of documenting instructions for end-of-life decisions.

In Hawaii, living will laws were enacted to assist physicians and families in the decision-making process when the patient is no longer able to communicate his or her choices regarding health care. Much credit can go to Dr Stephen Wallach and Jeffrey Crabtree, Esq, for their efforts in pushing for this 1991 legislation. Included in the thousands of living will booklets distributed by the medical society are living will samples as well as a checklist to specify whether food and water should be continued, withheld, or withdrawn. In 1992, legislation was passed which recognizes the right of an adult to appoint someone to make health care decisions on his or her behalf.

I believe the subject of living wills needs to be raised again: reminding those who didn't get around to signing a document to do so and to bring the issue before our younger physicians who may not be familiar with these laws. As advocates for our patient's well-being, we must discuss living wills with our patients and provide information regarding the importance of signing an advanced directive. Information regarding living wills is available at the HMA office.

Other issues that will affect our aging population are the need for adequate living facilities, long-term care and nursing insurance, streamlining entry into the long-term care system, and the need for maintaining independent living as long as possible are but a few issues currently being discussed at the HMA. The hospice concept also can be extended to well-planned and developed retirement communities and needs further discussion.

We must not confuse the issues of euthanasia and assisted suicide with the right to discontinue treatment. Physicians, who are entrusted with the living wills and directives of their patients, must provide assurance they will abide by these documents or recommend transfer to another physician. We need to keep in mind that patients are often fearful of becoming a burden to family or loved ones, and we must do what we can to relieve their anxiety. If we practice what we preach, we will also express our wishes to families and loved ones and sign a living will or declaration to make certain our colleagues have guidance regarding our personal directives.

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what if?

what if I need information on patient benefits?

what if I want to manage my office better?

what if my patient gets sick away from home?

what if I want to transmit claims over my computer?

what if I want to be a part of an HMO?

what if I don't?

what if I want a health care partner that listens?

what if Hawaii had a health plan with answers?

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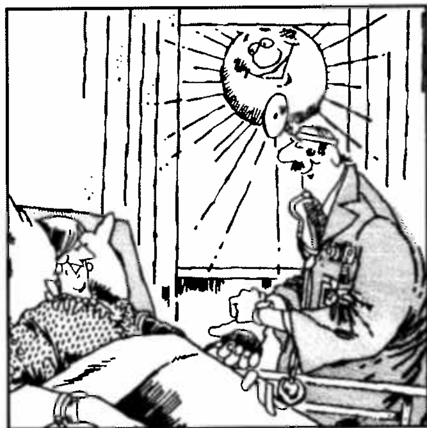
Choices for a Healthier Hawaii

How to Become the Positively Perfect Physician

Catherine A. Lee



As a lay editor at a medical school, I listened one day as new physicians held a soul-searching seminar on their professional manner with patients. Self and peer-criticism prevailed; these were young and earnest doctors, with at least near-perfection as their goal.

Unfortunately, they were going about it the wrong way. All they needed to do was read medical history, for therein lies the measuring stick for excellence. Doctors have been judging themselves for more than 2,000 years. The medical profession has set its own standards ever since the first exacting professor lectured to the first anxious student. And that began—in Europe, at least—some 400 years before Christ, when Hippocrates instructed Greek doctors-to-be.

Even before Hippocrates had joined the immortals, doctors in India and China were training apprentices in the healing arts of their culture. Almost from the beginning, professors of pulse and pills established strict criteria for the character, ethics and even appearance of medical practitioners.

Consider India. There, a doctor had to *look* like a doctor. Sanskrit writings of approximately the fifth century specified that a doctor-in-training should have more than just intelligence and a "chaste and benign demeanour." He also should have "thin lips, thin teeth, thin tongue, a straight nose, large, honest, intelligent eyes."

Hippocrates advised practitioners to wear "white, well-scented garments" and have hair and nails cut "not too long, or too short." Furthermore, a doctor should be "as plump as nature intended him to be"—for who would trust a skinny, undernourished medic?

Centuries later, Quaker physician (and signer of the Declaration of Independence) Benjamin Rush found young Yankee doctors lacking in bodily grace. He believed that Americans preparing to study medicine in Europe should spend an hour daily for three months taking dancing lessons.

But being a thin-lipped, sweetly perfumed, pleasingly plump twinkle toes does not a doctor make. Age, too, has always been a valued characteristic. But in any era where young men wear beards, the hirsute route to an aged appearance is useless (and no answer for women). On this topic laymen have offered a few morose comments.

Samuel Johnson, social critic of 18th century London, noted that medical men, "though ever so young, found it necessary to add to their endeavors a grave and solemn deportment." Benjamin Franklin got in his penny's worth of advice: "Beware of the young doctor and the old barber." To which physician-essayist Oliver Wendell Holmes added: "Age lends the graces that are sure to please. Folks want their doctors mouldy, like their cheese."

Ah well, time heals all things. While sages pondered ages, ordinary folks with ailments were asking more fundamental questions: Does the doc make house calls? How long do I have to wait to see him?

Sufferers of old could relax. Medical men who followed their preceptors' rules were instantly available. In seventh century China, physician-philosopher Sun Szumiao wrote a directive predating America's postal service ideals. Paul Unschuld translated in his *Medical Ethics of Imperial China*: "Neither dangerous mountain passes, nor the time of day; neither weather conditions, nor hunger, thirst, nor fatigue should keep [the physician] from helping whole-heartedly."

The land of Confucius also insisted the doctor be prompt, for "otherwise, the entire family of the patient will be in sadness and in fear, and will wait with sighs." In 13th century Italy, the government directed that "a physician shall visit his patient at least twice a day, and at the wish of the patient, once also a night." And in the English countryside of the 1600s, Shakespeare's son-in-law, Dr John Hall, rode horseback 40 miles to see patients.

These prompt, indomitable, bone-weary medicos at least reaped a psychological reward. Patients of the past *appreciated* their doctors. For example, in India it was polite to offer the physician a hot bath after his professional call.

Not only was he prompt, but a doctor trained in the 1200s at Italy's famous Salerno medical school made good use of the time spent reaching a patient. He was taught to ask the messenger who sought him out about the patient's symptoms as they traveled to the bedside. Then, the physician was assured, even if he could not make a diagnosis "after examining the pulse and urine," his surprising knowledge of the patient's complaints was sure to win the sufferer's confidence.

These warm-hearted Italian doctors knew all about the Bedside Manner. This began the moment one entered the house, when "the doctor should not appear haughty but should greet with a kindly, modest demeanour those present," according to historical accounts. He should then praise "the beauty of the neighborhood, the situation of the house, and the well-known generosity of the family, if this seems suitable."

However, in ancient China surveying the surroundings was considered crass, for patients were not to be judged by status and wealth. *Professional Admonitions*, translated by Paul Unschuld, stated: "Whenever beautiful silks and fabrics fill the eye, the physician is not allowed to look at them where...liquors are placed...he will look at them as if they did not exist."

Hippocrates had, of course, addressed that important first encounter between the sick and the healer. He advised medical men to "say something agreeable to the patient, flatter his sense,

➤ *Continued on Next Page*

and humor his fancies, if they are not dangerous."

Unfortunately, doctor-patient rapport has always carried with it a certain danger, especially if one is female and the other male. Threats to a male doctor's professional reputation often appeared in female form; both Asia and Europe learned to have a chaperone in a lady's sickroom.

However, near the 13th century the Chinese apparently relaxed the requirement. It was then that one Nieh Tsung-Chi discovered the perils of the boudoir. On two occasions, a woman whose husband was conveniently out of town sent for Nieh and tried to seduce him, offering him "my body in my bedroom." Twice, the physician—as straight as they come—"struggled free and ran away." Later, professional virtue brought its reward, via the supernatural route. Pleased and approving, the gods extended Nieh's life span from his ordained 60 to a ripe 72 years.

As for actual patient care, some recognition of humanistic medicine appeared many centuries ago. Writings on medical education in sixth century Spain stated: "The doctor should know something of music, for many things may be done for the sick with this art." In France, a 1306 treatise enlarged the scope of morale building. Doctors were told to raise the patient's spirits with music or "by forging letters telling him of the death of his enemies."

But suppose the patient—cheered, entertained, purged, pilled and pulsed—still is not getting any better. How does the good doctor handle this, er, grave matter?

In the City of Brotherly Love, Dr Rush suggested using "pious words when medicine fails." Italy's Salerno faculty taught doctors to tell the patient he would recover and warn the relatives that he was very ill. If he died, the relatives said the wise physician foresaw this, but if the patient recovered, the physician's fame was spread.

As to reimbursement, a crude sliding-fee scale was developed in ancient India, where physicians were advised to "treat gratuitously Brahmans, teachers, the poor, friends, neighbors, the pious, and orphans." Considering that the Hindu doctor studied for six years, one hopes he wasn't in debt for his medical education. In the golden days of Greece, Hippocrates told his followers: "Sometimes give your service for nothing, for where there is love of the art (medicine), there is also love of man."

Yet, doctors must eat and pay off the mortgage, so compromises were necessary. Early practitioners saw the value of charging fees. It took a pragmatic 14th century Frenchman to point out that you can't judge a book by the cover, for "wealthy people, when they go to see the surgeon, dress in poor clothing." A Salerno professor, observing flawed human nature, concluded that some charge must be made. He advised:

"Don't give your service gratis. Let not the wise muse of Hippocrates serve the sick in bed without reward, for medicine bought dearly benefits much; If something is given for nothing, no good results."

While the details of medical history, separated by country, class and century, are amusing, the essence of early medical precepts is not. Idealism seldom is, and the medical leaders of old were idealist. Indeed, they often functioned as judges of colleagues who failed to measure up. They censured the lazy ones of 17th century England who, gossiping in coffee houses, wrote prescriptions without seeing their patients. They frowned on medieval dandies throughout Europe who were conspicuous in "bright ribands, velvet bonnets, and embroidered gloves."

Long ago, medicine's standard bearers addressed the problem of advertising to build a practice. In the very beginnings of medicine in India, it was quite all right for a physician to walk through the streets saying, "Who is ill here? Whom shall I cure?" But early conservatives in Greece were embarrassed by fellow doctors who demonstrated their skills in open street stalls. Down through the centuries, Chinese physicians registered shame at colleagues who boasted of their ability and who used bold and conspicuous calligraphy on their name plaques.

Both practitioners and the public in 19th century Europe snickered at doctors who, summoned publicly from church, "went galloping throughout the town" to give an impression of a busy practice. In the American Colonies, disapproval greeted the man who, as the stagecoach approached, climbed on top of a huge rock, shouting, "I am a physician and surgeon."

These later critics followed a good and ancient example. More than 1800 years earlier, the famed anatomist-teacher Galen had heaped scorn upon doctors who used dubious methods to gain faithful patients. The methods ranged from flattery to the ultimate bit of unprofessional pleasantry—telling patients dirty jokes.

Perhaps medicine's bad boys merely illustrate a truth: Sin becomes conspicuous where virtue prevails. Even a light-hearted look at medical history reveals an insistence on professional probity. The ethical codes of East and West are remarkably similar. Both Indian and Chinese rules of conduct agreed with the Hippocratic Oath on holding doctor-patient communication sacred.

Doctors also were pledged to observe the equality of illness. "The physician should not pay attention to status, wealth, or age; neither should he question whether the person is attractive or unattractive, enemy or friend, uneducated or educated," read Chinese admonitions. In Italy of the 1500s, medical students were taught to approach the poor and low-born patient "as if he were a nobleman, since he differs in no respect from the latter, except by fortune."

Personal virtue and humanity equally were stressed. The physician in India was urged to be "chaste and abstemious...kind...speak the truth." The Chinese doctor must "above all have a marked attitude of compassion." In Greece, "he must be a gentleman in his character, and being this, he must be grave and kind to all."

All the essential criteria of character and ethics were outlined long ago. Any new physician can rate himself or herself against the requirements of medical history: Are you a person of benign demeanor; not too young? Are you prompt, sober, modest, and amenable to house calls? Are you well-barbered, neatly manicured, nicely plump, but thin-lipped? Musically knowledgeable? Nimble of foot? White of coat and sweet of smell?

Now look in the mirror.

Look carefully. Do you also have large, dark, intelligent eyes?

If so, then relax and rejoice. You are the positively perfect physician!

Reprinted from *The New Physician*, Reston, Virginia

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PPD Skin Reactivity and Anergy in HIV-Infected Patients in Hawaii

Cecilia M. Shikuma MD, Susan Congdon RN, Nancy Hanks RN, Scott Souza PharmD, Amy Kindrick MD, MPH*, Steven Case MS, and Margo Heath-Chiozzi MD

This study was a prospective screening study for PPD and anergy skin test reactivity in 304 HIV-positive individuals. A PPD positivity rate of 4.1% and an anergy rate of 50.5% were observed. The Hawaii HIV population has a relatively low prevalence of latent TB compared with the high prevalence of TB in the Hawaii population at large.

Introduction

Tuberculosis is a major cause of morbidity and mortality in HIV-infected individuals and constitutes an AIDS-defining opportunistic infection under CDC's Revised Classification System for HIV Infection.[1] The risk of progression from latent to active disease for a person co-infected with TB/HIV is estimated to be 7% to 10% annually as compared to a 10% lifetime risk in HIV-seronegative individuals.[2]

Among the opportunistic infections affecting HIV-infected individuals, tuberculosis is unique in that it is usually preventable and curable if detected early. Diagnosis of latent infection, however, may be difficult, as a high degree of anergy has been reported in the HIV-infected population, reducing the sensitivity of the tuberculin skin test.[3-5]

The CDC in April 1991 made several recommendations for the diagnosis of latent TB infection in HIV-infected individuals.[6] Specifically, recommendations called for companion testing with two delayed-type hypersensitivity (DTH) test antigens in association with the standard Mantoux method PPD tuberculin (5 TU) testing. A PPD cut off of ≥5 mm in this population was recommended as evidence of tuberculosis infection.

According to the CDC, in 1994 Hawaii had the highest TB case rate in the nation with 20.9 cases/100,000 individuals.[7] Little is known, however, about the rate of PPD reactivity in the HIV-infected population in Hawaii.

The aims of this study were to determine the rate of PPD reactivity in the HIV-infected community in Hawaii, to correlate the utility of PPD in this HIV population with a suspected high degree of anergy, and to correlate PPD and anergy result with immune status of these individuals as measured by peripheral blood absolute CD4 and CD8 lymphocyte subset determinations.

Materials and Methods

This study was a three year, prospective, single-center screening study for PPD and anergy skin test reactivity. HIV-infected persons age ≥12 years were recruited through AIDS service organizations and primary health-care providers for voluntary PPD and anergy skin testing. Participants were recruited from all major islands in the state. Demographic data including age, place of birth, ethnicity, HIV risk factors, history of previous PPD, and history of BCG vaccination were obtained for each participant. Three hundred individuals were targeted. Those with a history of sensitivity or intolerance to screening agents, history of previous positive PPD or history of tuberculosis were excluded.

The antigens and concentrations used to determine DTH were as follows: Tuberculin purified protein derivative (PPD) (Connaught Laboratories, Ltd, Willowdale, Ontario, Canada), 5 tuberculin units (TU) per 0.1 mL; mumps skin test antigen (MSTA) (Connaught Laboratories, Ltd, Willowdale, Ontario, Canada), 4 colony-forming units (CFU) per 0.1 mL; and tetanus toxoid fluid (Wyeth Laboratories, Inc, Marietta, Pennsylvania). The tetanus toxoid antigen was prepared by adding 0.2 ml of fluid tetanus toxoid to 1.8 ml of sterile albumin saline with phenol (Hollister Stier/Miles, Spokane, Washington), to provide a 1:10 dilution containing 0.1 LFU per 0.1 mL. Sterile albumin saline contains 0.9% sodium chloride, 0.03% albumin (human), and 0.4% phenol in water for injection. The skin tests were applied to the volar aspect of the right forearm using standard Mantoux technique. Skin tests were read once between 48 to 72 hours post-skin-test placement by trained personnel. The largest transverse diameter of palpable induration at each site was measured and recorded. A positive response was defined as ≥5 mm of induration in response to PPD and any induration in response to mumps or tetanus. Anergy was defined as negative response to all three antigens. Those individuals with less than 5 mm of induration to PPD underwent retesting with all three antigens.

Blood was drawn for T-lymphocyte subset analyses by flow cytometry within three months of skin testing. Patients with positive PPD and patients with anergy underwent medical evaluation by study personnel and chest x-ray examination for evidence of active tuberculosis. Those with positive PPD were referred for additional evaluation and treatment. They were offered enrollment into AIDS Clinical Trials Group 177 TB Prophylaxis study or referred to their primary physician or the Hawaii Department of Health.

Analysis of data to determine any significant differences or associations between variables was done using the chi-squared test of association with continuity correction and Fisher's exact test.

*Hawaii AIDS Clinical Research Program
University of Hawaii
3675 Kilauea Avenue
Honolulu, Hawaii 96816
This study is supported by the
Research Centers for Minority Institutions Grant No. RR 03061.

Results

A total of 304 individuals were enrolled in the study between January 1993 and March 1995 (Table 1). Complete results of skin test reactivity were available for 293 individuals. Results of T-lymphocyte subset data were available for 286 individuals. Not one case of active tuberculosis was identified.

A total of 133 individuals or 45.4% of all participants showed true negative PPD results (PPD negative, mumps and/or tetanus positive). A positive delayed-type hypersensitivity (DTH) response was observed most frequently with tetanus antigen (38.6%) followed closely by mumps antigen (36.2%). A positive reaction for both mumps and tetanus was seen in 25.9%. A total of 148 individuals showed no reaction to any of the three antigens, demonstrating an overall 50.5% rate of anergy (Table 2).

Some induration to PPD antigen was observed at 48 to 72 hours in 15 individuals (5.1%). Ten individuals had induration of ≥5 mm, meeting the CDC's criteria for a positive PPD in HIV-infected individuals.[6] The five individuals with less than 5 mm induration underwent repeat skin tests for all three antigens. One of these five individuals had an initial induration of 4 mm to tuberculin antigen and negative reaction to mumps and tetanus. Repeat tuberculin testing one month later revealed a 9 mm induration. Mumps and tetanus remained negative. He was counted as a PPD reactor. The remaining four individuals who were retested had a < 5 mm reaction or were nonreactive to PPD. Another individual initially showed no induration to tuberculin antigen at 48 hours but showed a delayed response to PPD 7 days later. He also was counted as a PPD reactor. Overall, a positive PPD was found for a total of 12 patients or 4.1% of the study cohort. None of these individuals reported a history of BCG vaccination.

Two of the 12 participants with positive PPD had negative reactions to mumps and tetanus. Seven had positive reactions to both mumps and tetanus. Two had a positive reaction to tetanus alone and one had a reaction to mumps alone.

A CD4 count less than 200/mm^3 was shown to be significantly associated with an anergic state as compared to a CD4 count greater than 200/mm^3 ($p < 0.05$). An inverse relationship of CD4 counts and anergy was seen (Fig 1).

Table 1.—Demographics

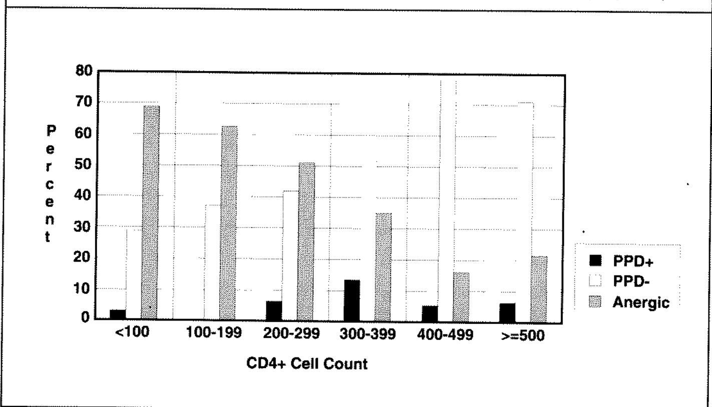
	No Patients (% total)
Patients entered	304
Age (Mean/Std dev)	40.5/8.0
Race	
African-American	6 (2.0)
Asian Pacific Islander	69 (22.8)
Caucasian	192 (63.4)
Latin/Hispanic/Portuguese	27(8.6)
Native American	10 (3.3)
Place of Birth	
Mainland	176 (57.9)
Hawaii	62 (20.4)
Foreign country	16(5.3)
Not given	50 16.4
Risk Behavior	
Bisexual	5 (1.6)
Blood transfusion	6 (2.0)
Heterosexual sex	19 (6.3)
Homosexual	222 (73.0)
Intravenous drug user	15 (4.9)
Sex with intravenous drug user or bisexual	3 (1.0)
CD444 count*	
≤50	72 (23.7)
51-199	65 (21.4)
200-499	100 (32.9)
≥500	49 (16.1)

*Available for 286/304 pts

Table 2.—Skin Test Results

	PPD	Anergy Panel (one or both)	N (%)
Positive PPD	+	+	10(3.4)
	+	-	2(0.7)
True Neg PPD	-	+	133(45.4)
Anergic	-	-	148(50.5)
	Total		293 (100)

Fig 1.—Frequency of antigen response according to CD4 T-Lymphocyte



Of the 12 individuals with positive PPD skin tests, four had CD4 counts of 200/mm^3 to 299/mm^3, three had CD4 of 300 cells/mm^3 to 399 cells/mm^3, one had CD4 of 400 cells/mm^3 to 499 cells/mm^3, and three had CD4 of ≥500 cells/mm^3. Only one individual had a CD4 count of less than 200 cells/mm^3. This individual had a CD4 count of <6 cells/mm^3, and was the individual previously described with a initial 4 mm reaction to tuberculin increasing subsequently to 9 mm on boosting. A significant association was found between having a CD4 count greater than 200/mm^3 and a positive PPD ($p=0.004$).

An interesting phenomenon of delayed skin-test positivity was observed in five patients. The original case involved a 36-year-old HIV-positive Caucasian man from Maui who was seen in September 1994. No induration was noted at the site of his PPD at 48 hours post-skin-test placement. He did have a 13 mm reaction to tetanus and a 4 mm reaction to mumps. The patient phoned our research office with information that he had noted a swelling in the region of his PPD seven days post placement of the skin tests. The positive reaction was confirmed and read as a 7 mm induration by the local HIV care coordinator nurse who is certified in tuberculosis testing. Unfortunately, no repeat PPD was done and the patient later died of non-TB-related causes.

All patients subsequent to this case were asked to call if indurations developed after the initial 48 to 72 hour reading. No other delayed reaction to PPD was reported. However, calls were received from four participants describing delayed reactions to tetanus and/or mumps from five to ten days post placement of the skin

tests. Two of these individuals underwent repeat skin testing. One of these individuals was initially anergic but reported a reaction to tetanus antigen at day eight. He underwent repeat skin tests two months later and had a positive tetanus reaction of 3 mm. No reaction was observed to mumps or tuberculin. The second individual, also initially anergic, reported a positive reaction to mumps and tetanus at day ten. He was retested four months later and had a 3 mm reaction to tetanus, and negative reactions to mumps and PPD.

Discussion

Hawaii has the highest tuberculosis case rate in the nation with 20.9 cases/100,000 individuals.[7] According to Richard Vogt MD of the Hawaii Department of Health in September 1995, of the 247 cases of active TB reported to the Hawaii Department of Health in 1994, 224 (91%) were Asian/Pacific Islanders and only 20 (8%) were listed as Caucasians. One hundred ninety five patients (79%) were foreign-born individuals with 127 patients born in the Philippines, 17 in Southeast Asia, and 11 from Korea. Tuberculosis in Hawaii is a problem largely of the immigrant population especially of Asian/Pacific Islander ancestry and not of the larger local population.

This study found a PPD reactivity rate of 4.1% among Hawaii's HIV-infected population, a rate much lower than expected given the high overall case rate in the state. Our study cohort consisted of 63.4% Caucasians and 22.8% Asian/Pacific Islanders, an ethnic composition closely matching the ethnic distribution of AIDS cases reported to the Hawaii Department of Health (66% Caucasians and 25% Asian/Pacific Islanders),[9] but very different from the ethnic distribution of persons with active TB in the state. Thus the HIV population in Hawaii appears to have a relatively low prevalence of latent TB and is a population probably distinct from the immigrant Asian/Pacific Islander population responsible for the high prevalence of tuberculosis in Hawaii.

An overall 50.5% anergy rate was found in our study. A strong inverse association between the lack of response to DTH testing and degree of immunosuppression as represented by CD4 counts was demonstrated. The rate of anergy varied from 22% in individuals with CD4 counts $\geq 500/mm^3$ to 72% in those individuals with a CD4 count of $<50/mm^3$. This high rate of anergy and inverse correlation with CD4 counts are consistent with other published reports.[3-5,10] Huebner et al studied a total of 479 HIV-infected persons at an HIV clinic in Florida and a tuberculosis clinic in New Jersey and found that anergy was four times and 15 times as likely for persons with CD4 T-lymphocyte counts of $200/mm^3$ to $400/mm^3$ and $<200/mm^3$, respectively, as for persons with >499 CD4 T-lymphocytes/mm^3.[4] Similarly, Graham et al reported an inverse linear trend for PPD positivity and CD4 lymphocyte count in a cohort of 260 individuals with history of intravenous drug use in Baltimore.[10] Brix et al reported a 5% anergy rate in HIV-infected individuals with CD4 counts $>500/mm^3$ while among individuals with ≤ 200 cells/mm^3 the anergy rate increased to 38%.[3]

Individuals with a positive reaction to PPD were likely to have a positive reaction to anergy testing. Ten of the 12 participants with positive PPD had a positive reaction to DTH antigens. This result is in contrast to the finding of Markowitz et al who reported no association between the response to control antigens and tuberculin reactivity.[5] Furthermore the ability to mount a positive reaction to PPD appears heavily dependent on the CD4 count of these individuals. Eleven of 12 participants in our study (92%) with a positive PPD had CD4 counts ≥ 200. Only one individual with a positive PPD was detected in the cohort with CD4 counts <200 despite the fact that close to 50% of the entire cohort had CD4 counts less than 200.

DTH testing is recommended by the 1991 CDC guidelines as an adjunct to tuberculosis skin testing in the diagnosis of tuberculosis.[6] The value of anergy testing, however, has been questioned lately especially in view of the recent study demonstrating fluctuation of DTH reaction over time in many HIV-infected individuals. An anergy study in a cohort of 923 injection drug users at methadone clinics in Baltimore between 1991 and 1994 demonstrated an initial anergy rate in HIV-seropositive individuals of 36% and in HIV-seronegative individuals of 14%. Among those who initially were DTH-positive, anergy developed in 24% of seropositive and 15% of seronegatives at the next study visit. Among those who initially were anergic, changes to a positive test took place in 15% of seropositive and 11% of seronegatives.[11] Our study supports the view that DTH testing is imprecise. Neither low CD4 counts nor anergy to DTH testing is completely predictive of a negative PPD as demonstrated by our two patients with negative responses to DTH who nevertheless had a positive reaction to PPD. One of these individuals had a CD4 count of <6. Our results argue that PPD skin testing should be considered in all HIV-infected individuals regardless of their state of anergy or CD4 count.

Recent studies have shown some, although limited, utility in boosting for those patients with insignificant (<5 mm) PPD and anergy. Huebner et al[6] found seven individuals from a cohort of 130 patients with initially negative PPD tests who responded to boosting. Webster et al[12] found 18 patients in a cohort of 709 HIV-infected patients who demonstrated a booster effect. These boosted responses were seen in 8 (2.1%) anergic patients, 6 (4.5%) nonanergic patients and 4 (2.5%) with anergy status unknown. In our study, five participants with <5 mm reaction to tuberculin antigen underwent skin testing for the second time. One individual was found to have a 9 mm response to the second PPD. Although numbers were limited in this study, boosting by repeat PPD may be of value in those with minimal induration (<5 mm) to tuberculin antigen.

A possible delayed reaction to PPD and anergy testing was observed in this study, with positive reactions developing after the standard 48 to 72 hours after placement of the skin tests. In one instance, 7 mm induration developed at the site of the original PPD seven days after placement. Unfortunately, no biopsies were performed to demonstrate a delayed hypersensitivity reaction. Subsequently, the two other participants self-reported delayed positive reaction to DTH. On retesting, both showed positive reactions to DTH antigen. We believe this phenomena should be studied further and that there may be utility in instructing patients to return if a delayed response is noted in order to confirm a positive reaction.

In conclusion, our study demonstrates that the HIV population in Hawaii has a relatively low prevalence of latent TB compared with the high prevalence of TB in the immigrant Hawaii population. Despite relatively advanced immunosuppression, PPD skin testing identified patients for TB prophylaxis. Skin test anergy was inversely associated with CD4 counts although no level of immunosuppression could be identified that could reliably predict skin test anergy. A phenomenon of delayed reaction to skin testing was observed and merits further study.

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News and Notes Henry N. Yokoyama MD

Life in These Parts

Lean Years Ahead

Hawaii Health Director **Lawrence Miike** reported in January that the Health Department will have to make do with $24 million less for fiscal year 1996. State Human Services Director **Susan Chandler** reported that her department will have $16 million less. The Aid to Families with Dependent Children program, which costs $12 million a month, will be cut by the federal government.

International Heart Program

Dick Mamiya, internationally known cardiac surgeon, retired from active practice after 31 years and will promote a Queen's Medical Center-sponsored heart program. In the past, Dick has treated more than 300 foreign patients. Income from bypass surgery on international patients currently runs $79 million per year (including housing costs for family members). Tim Yee, Chief Executive Officer for the Queen's International Corp, says patients from the Asia-Pacific region will keep Queen's Hospital beds filled. This market will bring new money to Honolulu, will have a multiplier effect, and will create new jobs.

Dialing for Flowers

Local plastic surgeon, **Dr Bob Flowers** is known for his *lifts*. He and his wife Susan got a lift of their own. Between their home and office, the two fielded eight requests for Valentine's Day roses. Typical questions: "Do you deliver? Do you do weddings? and Do you accept credit cards?" Dialing for Flowers may not get you a bouquet, but may give you a lift.

(From Hawaii—Dave Donnelly
Honolulu Star-Bulletin)

Letter to the Editor (In brief)

John Corboy wrote: "We continue to be assaulted by examples of thoughtless waste in ill-conceived government programs. It seems everything the state touches results in waste and mismanagement. The Health Quest program is an excellent example of the "spend first, plan later" mentality. As the program approaches bankruptcy from overutilization, it was decided to apply a means test for participants. This revealed that 40,000 persons are not even eligible. The waste of Quest runs $28 million per year. The only solution is to cut state spending by 20% per year until we return to accountable, bare bones government."

(Honolulu Star-Bulletin, February 16, 1996)

Kailua psychiatrist **Mark Stitham** writes: "Hawaii is one of only two states (the other is New Mexico) that levies a tax on medical services. The general excise tax on prescription drugs was eliminated a few years back. Hawaii should complete the process and follow the majority of other states in eliminating the "sick tax."

(Honolulu Advertiser, January 28, 1996)

News in Brief

The $30 million, 50 bed North Hawaii Community Hospital (funded with half state and half private funds) becomes operational in April. It has surgical and OB units and will offer critical care for accident victims and a variety of outpatient services for Waimea, Kohala, and the Hamakua coast.

The 26-bed Kahuku Hospital suspended maternity services in January for financial reasons. FP-obstetrician James Lew, who has worked under contract for two years, was notified that his contract will not be renewed. Jim delivered 120 babies last year and has about 80 patients at any one time. Kahuku Hospital has decided that it couldn't keep a maternity ward open and maintain other patient services.

In February, Renal Treatment Centers–Hawaii Inc (a subsidiary of Berwyn, Pa-based Renal Treatment Centers, Inc) announced plans to acquire Intercontinental Medical Services, Inc and its four centers for $24 million in stocks.

In January, Intercontinental treated 445 patients (about 38% of all cases in the state. Treatment of chronic renal failure is a $6 billion industry nationally with 2,500 facilities in the U.S. Medicare and Medicaid cover 70% of the patient cost.

Potpourri

A man ordered four expensive 30-year-old single malts and had the bartender line them up in front of him. Then, without pausing, he downed each one.

"Whew," the barkeep remarked, "You seem to be in a hurry."

"You would be, too, if you had what I have."

"What do you have?" the bartender sympathetically asked.

"Fifty cents."

(From Playboy Party Jokes, December 1995)

Overheard in a brokerage:

"I worry about economists who are so young that they think the Great Depression was ended by Prozac."

(The American Legion Magazine)

Jesus returns to Earth and goes into an ER and starts healing people.

The first guy is blind and Jesus heals him. Next is a deaf woman; he heals her. The next guy starts backing away and yells, "Stay away from me! I'm on Workers' Comp!"

(From Stitches, Nov-Dec, 1995)

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Locum Tenens

Locum Tenens.—For family practice, no OB or PEDS. GP, FP, IM are OK. Location Hilo, for two weeks, mid to end of July. Compensation negotiable. Contact Richard Lee-Ching MD, 780 Laukapu St, Hilo, (808) 961-6922.

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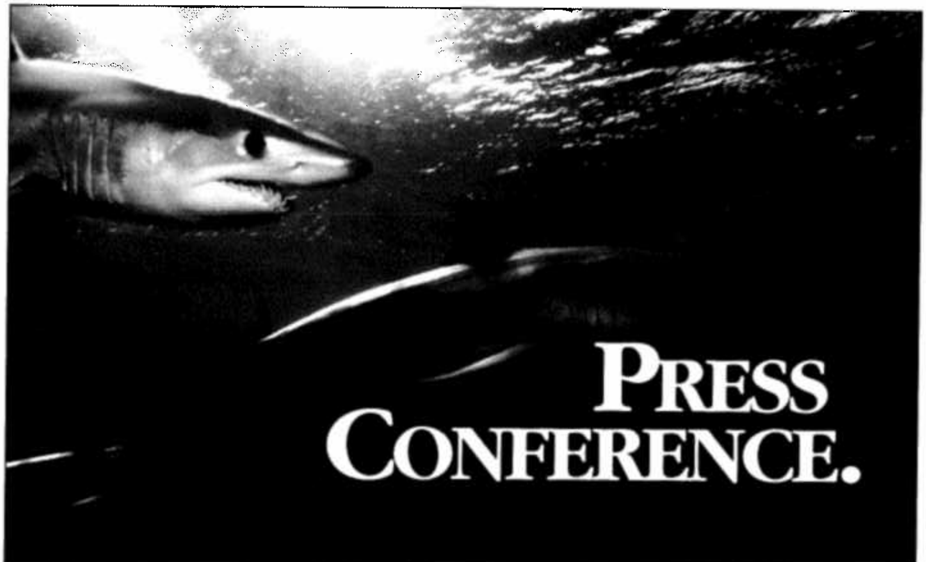

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The Weathervane

Win without boasting. Lose without excuse.

After a two-day hearing in U.S. District Court in Burlington, Vermont, Judge William Sessions, III, entered a consent order invalidating all claims at issue in Dr Samuel Pallin's patent infringement claim against ophthalmologist, Jack A. Singer MD. As ASCRS President Charles Kelman MD, stated, "This was the right legal result and the right result for society." Yes, society won, but in truth, the whole legal exercise was absurd from the onset, and the only real winners were the attorneys. No doubt they headed for the bank while laughing at these foolish doctors. Although some might say it is unfair, hereafter the name of Samuel Pallin MD will always be recalled as a symbol of arrogant cupidity. Sad to relate, although the AMA has declared such procedure patents unethical, several others have been issued in recent years.

You must decide whether to be the bird or the statue.

In Utah, a research team set out to establish the cost savings of a limited drug formulary used by six HMOs, including 13,000 patient studies. No practicing doctor would be shocked, but the research team was surprised when they found that a limited formulary actually increased the cost of pharmaceuticals to the HMOs when compared to an open formulary. Example—ineffective brand X had to be used because the doctor wasn't allowed to prescribe the more expensive brand A. Too often, the patient was obliged to make extra visits to the doctor, the pharmacy ultimately had to use the more expensive drug, plus the doctor lost clinical time while begging for permission to used appropriate medication. This HMO study demonstrated another example of why bean counters should not manage the practice of medicine.

I learned a lot from him by doing the opposite.

A plastic surgeon performed a blepharoplasty without apparent complications. The patient was unable to close her eyes after the surgery, and one week later was referred to an ophthalmologist who prescribed lubricating ointment. When a diagnosis of lagophthalmos was made, she brought a malpractice suit against the surgeon and a jury awarded her $540,000. However, the decision was reversed by the appelate court because the patient sought damages for "mental anguish." Therefore, the court ruled that the surgeon should have been allowed to depose the patient's psychiatrist and introduce this evidence at trial. He did not shrink from his duty.

The media: Remember, these people are not your friends!

Not fair! The Honolulu newspapers ran a story about the Hawaii Board of Medical Examiner's failure to punish errant doctors, suggesting that the Board was remiss and should get busy and crack down on black-hat physicians. However, the BME has no investigative arm (as do many other states), but must depend on referrals from RICO, the Regulated Industries Complaints Office, a branch of the Department of Consumer Affairs. It is RICO that investigates grievances, and RICO sends appropriate cases to the BME. Incidentally, any complaint made to the Hawaii Medical Association against a physician will be evaluated for reply only if the doctor is an HMA member (a big time member benefit). Actions against nonmembers must be sent directly to RICO.

Assuredly, this is dull stuff, but vital.

Computer-generated problems are an increasing medical expense. In 1993, more than 41,000 workers suffered from carpal tunnel syndrome requiring time off from work, and costing insurers $50 million in claims. At least 20% (and probably more) of these came from typing. The areas of complaint are the eyes, wrists, shoulders, and neck. Ergonomic medical experts recommend the following: (1) to avoid eyestrain, place the computer screen 26 inches from the eye, center it four inches below the eye and, if glasses are necessary, use a full lens not a multifocal. (2) Do not use wrist rests or splints which put pressure on nerves and can lead to muscle atrophy. (3) The keyboard should slope 12 degrees away from the typist with the back lower than the front, and should be situated one to two inches above the legs. This allows for better hand position, reduces shoulder shrugging, neck tension, and elbow problems. (4) Keep the mouse platform 20% higher than the elbow, in front (not to the side) of the body, and do not squeeze the mouse.

A doctor feels about lawyers like a fire hydrant feels about dogs.

A major shift has occurred in malpractice complaints in recent years with fewer and less-expensive surgical cases and an increasing number of *failure to diagnose* cases. In 1990, failure or delay in diagnosis amounted to 19% of cases, but by 1994 the number jumped to 43% and accounted for 40% of all indemnity. By contrast, surgical liability cases dropped from 19% to 11% and amounted to only 4% of total indemnity in 1994. Surgeons are increasingly scrutinized by quality review and pre-authorization, but meanwhile, managed care plans have restricted diagnostic tests, forced busier schedules, and caused physicians to see patients whose medical history is not well-known to them. Thus, gatekeepers (GPs and internists) have become larger and more vulnerable targets as trial lawyers relentlessly probe for deep pockets.

An economy breathes through its tax loopholes.

If you are worried (who isn't?) about an IRS audit, the worst town to live in is Las Vegas with an audit percentage of 2.92%. Contrarily, Milwaukee is the least likely with a rate of 0.32%. Of course, other factors enter such as income over 100K, self-employed, and corporations with assets over $1 million. Still, stay optimistic, the odds are 99 of 100, that you will not be visited by the IRS.

Addenda

- Annual routine maintenance for the excimer laser is $40,000 to $70,000.
- If it's called tourist season, why can't we shoot them?
- California Association of Consumer Advocates is the new name for the trial lawyers club. What a lovely new acronym—CACA.

Aloha and keep the faith—rts.

Michael D. Rudy, Esq.

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