

Correspondence

Patients' Presence in Prenatal Screening

TO THE EDITOR: I found the epitome, "Advances in Prenatal Screening," by Ganiats and Baughan in the March issue interesting but puzzling.¹ There appear to be two parallel ways of thinking about prenatal care issues: patient-centered and technologic. The "public health" approach as described by Ganiats and Baughan represents the technologic approach exclusively. Education of the patient as to important issues in managing her own pregnancy is not even considered. Certainly, they have covered nicely all the tests to do at what point in pregnancy, but patients and physicians get into trouble because of what patients do or do not do, or what physicians tell them or do not tell them, and how the communication goes wrong. When an outcome is bad, technology often does not help the mother or the physician, only the malpractice attorney. Let's get the *patient* back into "advances in prenatal screening."

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Blastocystis hominis

TO THE EDITOR: Babb and Wagener, in their retrospective study of *Blastocystis hominis* in the November 1989 issue,¹ compare their findings with ours² and come to the opposite conclusion, namely that "*B hominis* is a potential pathogen that can in some patients lead to diarrhea and abdominal pain." Let us examine the basis on which they base this not-very-emphatic endorsement of its pathogenicity.

Some 3% of 2,700 patients who had stool examinations done during a one-year period were found to have *B hominis* in their stools. Of medical records examined, 65 contained relevant clinical information. Of these 65, however, fewer than three stool specimens were submitted by 24 persons. Sawitz and Faust, whose exhaustive study is still our only guide in this regard, conclude that only about two thirds of *Entamoeba histolytica* infections are discovered in two stool examinations, by a combination of techniques including but not limited to stained slides.³ The other 41 patients had at least three stool examinations, which by Sawitz and Faust's calculations would reveal about 80% of such infections. There are no comparable statistics for *Dientamoeba fragilis* and *Giardia lamblia*. Our own experience, based on patients who had a minimum of six stool examinations, each examined not once but by two licensed microbiology technologists and one of us (E.K.M.), showed it was possible to miss *Giardia* on six such consecutive examinations. Thus, we can conclude that it is probable that some of these 65 patients had undetected amebic or flagellate infections.

In this study, about half (33 of 65) received no treatment, either because they were asymptomatic from the start or because their symptoms cleared up promptly. Of the remaining 32, half (16) had recognized parasites. Both *E histolytica* and *Giardia* respond to treatment with metronidazole, and

dientamoebiasis is often asymptomatic. Thus, nothing can be concluded from the favorable response of these 16 patients.

There remain 16 patients who were proper subjects for the study. How many of these had even three stool examinations we do not know, but only 3 of them had even a single follow-up examination. Most became asymptomatic after treatment (it is impossible to tell how many because the authors do not differentiate between the two different patient groups), but these statistics do not justify any conclusions as to the pathogenicity of *B hominis*. Although costly and time-consuming, an adequate number of stool examinations must be done—and preferably checked as we did by several persons—with an adequate number of follow-up examinations after treatment, before drawing any conclusions as to the pathogenicity of an organism whose appearance in the stools of a symptomatic person may be as coincidental as that of *Entamoeba coli* or *Endolimax nana*. Babb and Wagener imply that we consider "functional bowel syndrome" as a convenient catch-all for those patients with *B hominis* in whom we were unable to find recognized pathogens. On the contrary, all those to whom this diagnosis was assigned fulfilled all the recognized criteria for this diagnosis at follow-up examinations for an average of 30 months.

Most of the articles cited by Babb and Wagener are single-case reports. They do not mention the work of Miller and Minshew,⁴ who were unconvinced of the pathogenicity of *Blastocystis* on the basis of their own study of 11 patients and a review of the literature, or that of Chen and co-workers,⁵ who by using immunoblot analysis were unable to detect any serologic response from four patients with a diarrheal syndrome associated with the presence of *B hominis*, in contrast to what is seen with known intestinal pathogens such as *Giardia*.

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Espresso Maker's Wrist

TO THE EDITOR: Food service workers are subject to a variety of cumulative trauma disorders, including carpal tunnel syndrome (grocery checkers) and pressure neuropathy of the deep palmar branch of the ulnar nerve ("pizza cutter's palsy").^{1,2} Reported here is a case of de Quervain's tenosynovitis in a novel occupational context.

A 41-year-old restaurant owner was noted by this physician-customer to be wearing an elastic bandage on his right (dominant) wrist. Upon inquiry, he reported a two-month history of gradually increasing pain of the radial aspect of the joint. The pain was exacerbated each time he inserted spigots