percent of diabetic men who retain their potency than in those allegedly impotent because of their disease. It is well known that potency may be retained, or impotency may develop in a diabetic man without correlation with the severity or the control of the disease. Testosterone therapy alone, or with chorionic gonadotrophin, has not been successful in overcoming impotency in diabetes, according to Kolodny et al.[5]

None of Spark's patients received any placebo. A double-blind study would be very important, particularly since I have learned from my clinical experience that many instances of transitory response (if any at all) to "potency medication" result from a three-way interaction, namely, the quests of an *expectant patient* for help from a purportedly *knowledgeable physician* who gives an *allegedly useful medication*—rather than from any pharmacodynamic effect of the medicine itself.

In a lengthy review of the relationship of hormones to aging, Davis concluded that ". . . loss of sexual potency is so complex a process that it is not justified to attribute it primarily to decreased androgen production."[6] I agree.

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Triamcinolone and Keloids

TO THE EDITOR: The epitome of progress "Triamcinolone for Hypertrophic Scars and Keloids," which appeared in the July 1980 issue, merits comments.

Like Dr. Brody, I believe that intralesional injection of triamcinolone is the best currently available treatment for keloids. However, there are three, not two, commercially available respiratory triamcinolone injection materials. Triamcinolone hexacetonide was not mentioned. This salt is the least soluble, and therefore the longest acting of the respiratory triamcinolone preparations on the market. Intralesionally given corticoids are widely used in dermatologic practice. Like most dermatologists, I prefer triamcinolone acetonide (Kenalog). However, I am not aware of any studies comparing the efficacy of the acetonide with the hexacetonide salts in the treatment of keloids.

Triamcinolone acetonide persists in tissues—and therefore has a period of action of three to four months; not the "up to four or five weeks" claimed by Dr. Brody. This is of practical significance; the maximum keloid regression will usually be observed toward the end of this period, and therefore patients should be seen at three- to four-month intervals.

Dr. Brody suggests that the injections may be either preceded by local infiltration of lidocaine or else the triamcinolone suspension may be mixed with local anesthetic before administration. The latter alternative is poor advice. Triamcinolone acetonide—unlike lidocaine—does not by itself sting on injection. The discomfort of injecting keloids without anesthesia is due to a combination of needle prick pain, plus the pain of injecting fluid under pressure. These are instant, but brief, pains; adding lidocaine to the suspension only adds the lidocaine "sting." If a 30-gauge needle is used, injection into small keloids can usually be done without anesthesia. With large keloids, or when the patient is sensitive, Dr. Brody's first suggestion of preliminary infiltration with lidocaine is the appropriate procedure.

Dr. Brody mentions side effects without clearly distinguishing between local and systemic ones. I would disagree with the arbitrary statement that "The maximum dosage is 60 mg. (1.5 ml) every 30 days." This amount of triamcinolone acetonide once a month will completely suppress endogenous corticoid production, and also cause significant systemic effects. Atrophy is the main local side effect—it is of course recognized that atrophy of the *keloid* is the aim of treatment. Too concentrated a corticoid, or too superficial an injection, will lead to *epidermal* atrophy which can cause a very unsatisfactory result. Epidermal atrophy is more likely to occur with the 40 mg per ml triamcinolone acetonide formulation (Kenalog-40), and that is why I usually start with the 10 mg per ml injection.

A few words about the technique of injection. A fine needle (30-gauge) on a tuberculin syringe equipped with a Luer lock should be used. It takes pressure to get the material into a keloid. The in-

jection is *not* intradermal, but intralesional, at a depth of 3 to 7 mm, sometimes more in the case of a thick keloid. The injections should be spaced about 1 cm apart, and only a small amount—about 0.05 ml—injected at each site.

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Medicaid in California

TO THE EDITOR: I read the article by Beverlee Myers, "Medicaid and the Mainstream: Reassessment in the Context of the Taxpayer Revolt" (West J Med 132:550-561, Jun 1980), with much interest, especially with regard to the various ways the Department of Health Services is going to control the costs of the Medi-Cal program. However, there is no mention of the cost-effectiveness of the proposed program. I also have not come across any reference relating to the administrative costs of running the California Medicaid program (Medi-Cal). I have heard that the administrative costs for the Medi-Cal program run as high as 50 percent (estimated by the Little Hoover Commission). I would like to know if Ms. Myers would like to comment on this.

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Ms. Myers Replies

TO THE EDITOR: In response to Dr. Loh's question regarding the cost-effectiveness of the proposed Medi-Cal Restructuring Plan, the Department of Health Services has estimated these reforms would achieve cost savings of approximately 15 percent to 20 percent at the end of a five-year implementation period.

As for Medi-Cal's administrative costs, direct administrative costs are approximately 7.3 percent of total program costs, or about $300 million annually (not counting administrative costs of providers which are included in their payments). A little over half of this administrative cost (55 percent), about $150 million per year, is incurred determining and redetermining eligibility for Medi-Cal benefits; 25 percent is related to fiscal intermediary operations—the process of paying provider claims for services to Medi-Cal beneficiaries; 7 percent is allocated to field services and recovery activities (prior authorization of certain expensive Medi-Cal services, such as inpatient hospitalization, and recovery of funds inappropriately paid by the program); 5 percent is incurred by audits and investigations, and the remaining 8 percent supports all other functions.

The Little Hoover Commission's estimate in 1976 that total administrative costs *may* approach 40 percent went beyond the direct administrative costs discussed above. In addition, it included estimates of provider administrative costs and assumptions about large amounts of program overuse and fraud and abuse by providers and beneficiaries. Such estimates and assumptions are not generally included in the calculation of health insurance administrative costs.

Medi-Cal's 7.3 percent direct administrative cost compares very favorably with those of private health insurance organizations. As reported in the *Statistical Abstract of the United States*—1979, published by the United States Department of Commerce, private health insurance organizations' administrative costs were 12.8 percent of their premium income in 1976. If Blue Cross/Blue Shield is excluded, this figure rises to 18.9 percent.

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County Hospitals, Medi-Cal and Programs of Reform

TO THE EDITOR: I was glad to see the perspective of Beverlee Meyers and Rigby Leighton ("Medicaid and the Mainstream: Reassessment in the Context of the Taxpayer Revolt") in the June 1980 issue. As one who has been a student in and employed by various county hospitals in California for 12 of the last 16 years, primarily serving the Medi-Cal (California's Medicaid program) population, I would like to offer some comments from that perspective.

First, Myers and Leighton speak of legislative and administrative "attempts to limit participation to efficient facilities." They are, I believe, referring to attempts to restrict hospital admissions primarily to county hospitals. County hospitals are strapped with facility, administrative and personnel problems that make them very unlikely candidates for restructuring their medical care delivery systems to become less costly if reorganized in this manner. Medi-Cal at present reimburses a private provider about $10 for a brief office visit. It reimburses hospital outpatient clinics about three times more than this (and emergency rooms are reimbursed even more) for the same level of