

so that the cost of VDRL screening for women was a \$7 laboratory charge plus a \$5 charge for blood drawing and handling? This would reduce costs by \$15 per visit with no clinical loss whatsoever. Total savings would be \$4.5 million, or 53% of the total assumed costs of yearly screening. Cost per case of syphilis identified would then be reduced to about \$113,700 in round numbers. This is not an outrageous amount and using Dr Haskell's worst case method the screening would then appear to be cost-effective.

I would conclude, therefore, that rather than discontinue VDRL premarital screening, we should eliminate physician visits and fees which have no place in the screening procedure. I would still eliminate rubella screening and instead substitute documentation of vaccination. We could save even more money if costs for the screening were fixed. This could be accomplished by regionalizing laboratories performing screening on a competitive bid basis and either fixing clinic blood-drawing fees or similarly regionalizing sites where blood specimens for screening were to be drawn.

This seems to me to be a classical case of one potential pitfall in cost-benefit analyses—much depends on the assumptions inherent in the calculation process.

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Break Dancer's Fracture of the Fifth Metatarsal

TO THE EDITOR: Recently, break dancing has become a very popular form of entertainment in the United States. Break dancing involves expressive gestures of the head, arms and body while using steps designed to produce a fluid appearance of movement, periodically punctuated by back spins on the arched upper thoracic spine. As with any new activity, it is not surprising that previously uncommon injuries should become manifested with increased frequency. I would like to report one such break dancing-related injury.

A 17-year-old young man in good health presented to the emergency room complaining of the sudden onset of sharp pain on the lateral aspect of his right foot, which was coincident with the premature planting of this foot while performing a lateral slide step. (This is a common maneuver in break dancing, in which the undersurface of the shoe is kept just above and parallel to the floor or street while moving laterally, after which weight is gradually shifted to that foot.) On physical examination minimal swelling and moderate point tenderness were noted just proximal to the fifth metatarsal-phalangeal joint along the lateral aspect of the right foot. Ankle and foot radiographs showed a normal ankle and a spiral fracture of the distal midshaft of the fifth metatarsal.

Four types of fractures of the fifth metatarsal occur with

any frequency. These include stress fractures in athletes,¹ and tuberosity and Jones's fractures² related to the tendinous insertion of the peroneus brevis—all three of which occur at the proximal end of the metatarsal. Fractures of the midshaft and neck are usually transverse and due to heavy objects falling on the foot.¹

Given the position and direction of motion during the lateral slide step during break dancing, the spiral midshaft fracture suffered by this patient likely resulted from the combination of a rotational force about the long axis of the foot plus a medial load on the distal half of the metatarsal. This is similar to the direction of force in an inversion sprain of the ankle, but with a more distal focus of maximal force.

With the increasing popularity of break dancing among American youths, certain previously uncommon injuries can be expected to be seen with greater frequency, including fractures in unusual locations. Physicians should have a heightened level of suspicion when evaluating patients injured during break dancing until all associated injuries are known.

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Methods of Determining Blood Pressure

TO THE EDITOR: I read with interest the article on auscultatory blood pressure measurement by Drs Londe and Klitzner¹ in the August issue.

Although I have noticed few other people who use the technique that I use in auscultating brachial blood pressures, I personally use the bell of the stethoscope as recommended by DeGowin and DeGowin in their text *Bedside Diagnostic Examination*.² On page 387 of the third edition, their recommendation is "press the bell of the stethoscope lightly over the brachial artery and note the pressure read at which sounds first become audible . . ." I assume that the DeGowins presumed the findings of the study by Londe and Klitzner and therefore recommended this technique as the preferable way of eliciting blood pressures. I do not know why most people use the diaphragm of the stethoscope and would be interested in the authors' feelings about the DeGowins' method of determining blood pressures. Perhaps comparing assessment of blood pressure with a bell applied lightly to the brachial artery versus a diaphragm could be the subject of a study.

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Dr Londe Replies

TO THE EDITOR: Dr Meth raises an important question.

I have been using the bell side of the stethoscope because I was using a bell stethoscope when I began my studies in

childhood hypertension over 20 years ago. Furthermore, the sounds produced during auscultatory blood pressure measurement are heard better with the bell side.

However, sometimes the solution of one problem creates another. With little or no pressure on the bell side, there frequently is some space left between the arm surface and the stethoscope because of the irregularity of the arm surface. Consequently, the sounds are either very faint or not audible at all. Use of the diaphragm side eliminates this problem and I am now using the diaphragm side.

Dr Meth's suggestion that a study be made comparing the bell versus the diaphragm with light pressure is a pertinent one. I have tested this a few times and have found the same lowering effect on the diastolic reading when firm pressure is applied to the diaphragm side. This needs documentation with measured amounts of pressure.

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Medicare's Future

TO THE EDITOR: It was with dismay that I read your editorial entitled "Medicare—Progressively Overburdened and Underfunded" in the September 1984 issue.¹

Your reference to Victor Fuchs's observations were both interesting and relevant to the discussion of Medicare's future. Fuchs observed that in 1935 "when the age of eligibility for social security retirement benefits was set at 65, life expectancy at age 65 was about what it is now at age 72."

Unfortunately, your editorial's ensuing support for a redefinition of old age and Medicare eligibility to age 72 overlooked several critical issues:

- In today's society, there is a tendency for people to retire earlier, making it far more difficult for the aged to pay the high cost of adequate health care. And, let us not forget that with today's retirement also comes a loss of costly private health insurance.

- Rolling Medicare eligibility back to age 72 would extract a terrible price in human suffering for those unable to pay the price of needed health care.

While an eligibility roll-back may keep Medicare solvent, it would not preserve the intent of the 1965 legislation, nor solve the underlying problems Medicare was established to address. Your references to an "emotional hue and cry" and to "special-interest groups" in speaking of the opposition to a proposed roll-back serve only to cloud these underlying issues.

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More on Pains Cured by Examination

TO THE EDITOR: Recent discussions with colleagues concerning cure of pelvic and abdominal pain through pelvic examination^{1,2} have elicited another hypothesis and an intriguing case history.

The hypothesis is that partial torsion of a relatively mobile structure, such as sigmoid colon or ovary, might underlie some cases, and might be relieved after the simple manipulation inherent in examination.

The case concerns a 44-year-old internist, previously and afterwards healthy, in whom sudden, severe and unremitting right lower quadrant pain developed, which radiated to groin and vulva. Upon light abdominal palpation by a colleague, the pain remitted abruptly; urinary urgency followed, with painless passage of a stone. The apparent mechanism of pain relief was migration of a urolith, probably ureteral. The timing suggests a relationship between the events; however, the deep retroperitoneal location of the ureter should prevent effective transmission of surface pressures, especially slight ones, and alternative explanations (unrelated events, or events related by unknown means) cannot be dismissed. If several other cases were reported, the entity of "examination-assisted stone migration" might be established no matter how obscure its mechanism.

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Preoperative Evaluations

TO THE EDITOR: Levinson's report in the September issue¹ on the value of preoperative evaluations by an internist does not suggest, as Abrams concludes in the accompanying editorial, "a well-founded basis for the routine preoperative evaluation for patients undergoing eye surgery in a general community hospital."^{1,2} In fact, the study is fundamentally flawed and unable to support any important conclusions regarding the question at hand.

First, whether a patient received a preoperative visit by an internist "was determined by the ophthalmologist." Consultations were performed on 258 patients, but we are told nothing specific about the cases for which consultation was not requested. Without at least minimal information regarding this group, one cannot possibly justify any conclusions regarding the value of routine preoperative evaluations.

Second, the benefit is questionable even in the selected patients who received a preoperative evaluation. We are told that 51/258 patients had "conditions considered important to surgical risk," but the literature cited to justify these conditions as risk factors is derived mostly from studies of patients undergoing general anesthesia for general surgery. The relevance of these supposed risks to ophthalmological surgery is unclear, especially since eye patients commonly receive only local anesthesia and mild sedation during their operations. Further, assignment of risk factors to individual patients was apparently subjective in many instances. For example, 26/59 risk factors cited were "severe chronic lung disease" or "severe asthma." No objective data are presented to justify the assessment of severity in these patients; the internists' impressions are simply taken at face value.

Even if we grant that many true risk factors were discovered, was this of any benefit to the patients? Only five actual