ARCHIVES OF FAMILY MEDICINE

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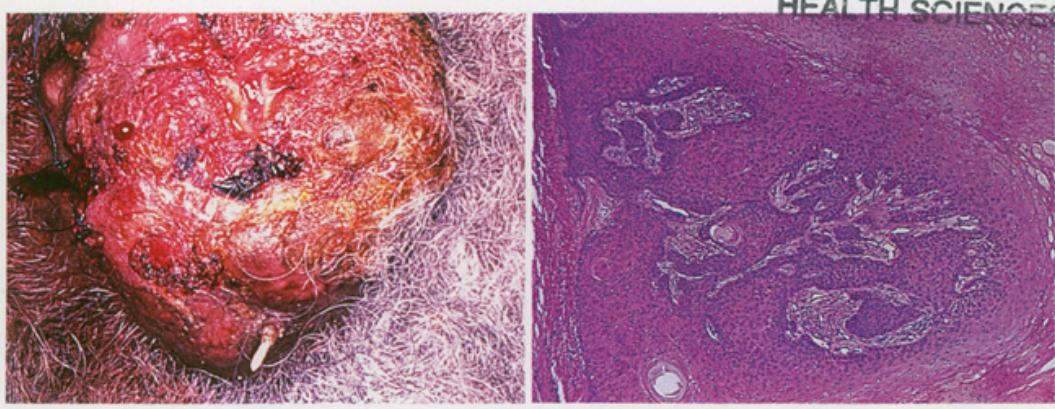

See Special Selection, page 191.

American Medical Association
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DIAGNOSIS: Proliferating trichilemmal cyst (PTC).

HISTOPATHOLOGIC FINDINGS

Compact hyperkeratosis and areas of scale-crust were seen. An intradermal tumor composed of lobulated, well-circumscribed squamous epithelium was seen extending to the subcutaneous fat. The lobules had a basaloid peripheral palisading layer and exhibited abrupt trichilemmal keratinization with formation of homogeneous keratin cysts. No cellular or nuclear atypia was seen. Foci of calcification and a lymphohistiocytic infiltrate were present.

DISCUSSION

Proliferating trichilemmal cyst is thought to arise from a preexisting ordinary trichilemmal cyst following trauma and inflammation.[1,2] A PTC is often lobulated and can undergo ulceration greatly resembling squamous cell carcinoma (SCC).[2,3] Multiple lesions have been reported.[1,2,4] In 90% of cases, the tumor occurs on the scalp; in 10%, on the neck.[1-3] There is a predilection for females (84%).[1-3]

On light microscopy, PTC can be confused with SCC at first glance. However, there are key differentiating histologic features. These include well-demarcated lobules of squamous epithelium with noninfiltrative peripheral palisading borders that rest on a thick hyalinized basement membrane.[2,3] Although occasional foci with a slight degree of cellular and/or nuclear atypia and dyskeratosis may be present, PTC, unlike SCC, lacks severe dysplasia or invasion.[2,3] The abrupt change from squamous epithelium to eosinophilic keratin (trichilemmal keratinization), identical to that seen in trichilemmal cysts and reminiscent of the outer root sheath of hair, favors PTC.[2,3] Foci of calcification and dermal inflammation, usually lymphohistiocytic, are often associated with PTC.[2,3]

Due to the mode of differentiation, PTC is thought to be derived from the outer root sheath (follicular isthmus).[2,3] In addition to trichilemmal keratinization, a form of cell maturation that occurs normally in the stratified epithelium of the follicular isthmus, PTC also features vacuolated glycogen cells typical of the outer root sheath.[1,2]

The differential diagnosis may include SCC, other adnexal tumors (ie, clear cell hidradenoma), deep fungal infection, and pseudoepitheliomatous hyperplasia of bromoderma and iododerma. These entities can be excluded on histopathologic examination, since they do not demonstrate features characteristic of PTC. The PTC is considered a benign neoplasm; its treatment is surgical excision.[2] There have been reports of malignant transformation with metastases.[1,2] In these instances, the neoplasm rapidly enlarges and exhibits severe cellular atypia and invasion of surrounding connective tissue.[1,2]

Selected from Arch Dermatol. *1995;131:719-724. Off-Center Fold.*

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Clinical Pearl

Kids swallowing coins: if it is in the proximal or middle third of the esophagus, it probably will not pass spontaneously. If it is in the distal esophagus, observe; it may pass spontaneously. (*Arch Pediatr Adolesc Med.* 1995;149:36-39.)

sition, and it was left to me to find a job. At a time when I felt vulnerable, fragile, and punished for my illness, I had to go out and search for a new job. I talked with other clinics in my community, but they were not interested or comfortable in working with me.

Prior to my suicide attempt, I had heard positive comments about my work. I am a competent and caring physician. After I attempted suicide, no one in my community would work with me. I do not like being sick. It hurts to say I have a mental illness. The punishment and shame I felt from losing my job and being shunned by my medical community intensified those feelings. As Dr Bauman stated, "we expect perfect mental health in ourselves and in our peers." Only perfection will do. To deny our vulnerability to illness and its effects is to deny our humanness. Is this the message we want to continue to convey in our profession?

I am now committed to being alive. I have a new job, 300 miles away from familiar surroundings and the people who could have provided support. I hope the day will come when depression is truly seen as a treatable medical illness in our colleagues as well as in our patients, so that job loss and personal rejection do not have to be the outcome of a failed suicide attempt.

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1. Bauman KA. Physician suicide. *Arch Fam Med.* 1995;4:672-673.

In reply

I thank Dr Eilers for her courage in sharing her story. I was in academic family medicine at the time of my husband's unexpected and untimely death by suicide and I received excellent support in my recovery. This experience, plus the fact that family physicians take care of so many depressed patients, led me to believe family practitioners would provide an understanding and supportive environment for physicians like Dr Eilers. This may not be the case.

As I reflect now, I realize that people in general, not just physicians, are finally learning how to respond to a person who has had a loved one die. They can say, "I'm so sorry!" or even, "I just don't know what to say," and include a warm handshake or a quick hug. Faced with a colleague with a mental illness, physicians can be at even more of a loss for words. Instead of saying similar things, they say nothing, causing rejection and isolation.

Students often ask me, "What could people have done to be more helpful?" At risk of sounding like Ann Landers, perhaps I can suggest factors or ways of behaving that would have worked better for Jim and for Dr Eilers.

1. Physicians, like others, need adequate mental health insurance coverage that includes diagnoses such as depression, alcoholism, and substance abuse.

2. Send frequent cards or brief notes to colleagues who are recovering from any of these medical problems. Don't expect answers every time. Maintain your links to that physician.

3. Recognize a "teachable moment" for the office or department, and hold conferences on related mental health topics so all are informed and welcoming when the ill person has recovered sufficiently to return to work. Remember the high recovery rates for many of these diseases, for example, 80% to 90% for alcoholic and addicted physicians.

4. Involve the recovering physician in plans for his or her work schedule on return and the role he or she would like to play in continuing education on pertinent mental health topics. At times the recovering physician may choose to teach others as a part of his or her recovery process.

5. Allow time off for follow-up care.

6. Respect the confidentiality of the situation.

I would wish that we could create supportive environments in our workplaces so that, as Dr Eilers states, "depression is truly seen as a treatable medical illness in our colleagues as well as in our patients," and I would change her closure to, so suicide isn't attempted!

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cational tool for this population, there may still be a role for educational videotapes as adjuncts to written material and patient-clinician discussions. A revised videotape may need to tailor information to the audience's cultural and educational background. An interactive videotape may also be a more engaging format to convey complex information in an individualized manner. Research centers are currently studying the effect of more interactive videotape formats on patient decisions for medical care.[32] Advance health care planning is difficult to master. We need to pursue more effective methods of conveying information about life-sustaining treatments and advance directives to older patients and other patient groups who have difficulty understanding these concepts.

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Clinical Pearl

Plasma homocysteine level appears to be a risk factor for carotid stenosis as well as coronary artery disease: the higher the plasma homocysteine level, the higher the incidence of the disease. Vitamins B_6 and B_{12} and folic acid are needed for homocysteine metabolism and may be protective. Eat your fruits and vegetables (at least five servings a day). (*N Engl J Med.* 1995;332:286-291.)

tion.[8,9] That 20% of the people in the study by Siegert et al wanted CPR even if they had incurable cancer only demonstrates that subjects did not understand the limits of that therapy. These possible limitations of the study point to the challenges of communicating effectively to patients about these issues.

Why is it so hard for physicians and patients to come to realistic decisions in long-term care settings? First, as a culture, we seem to be infinitely optimistic about the benefits of medical therapy. We regularly watch on television the glories of medical interventions, particularly CPR. Second, although CPR was developed as treatment for anesthetic accidents, trauma, or arrhythmia, we have freely applied this therapy in futile circumstances, including sepsis, metastatic cancer, renal failure, and poor functional status.[10] Third, we have extended the hospital practice of requesting and writing do-not-resuscitate orders to a setting (long-term care) in which CPR is rarely appropriate. Compared with the nursing home, the hospital has different patients, different support systems of care (ie, code blue teams), and different expectations for treatment. Fourth and probably most important, in our efforts to forestall death, we focus on the one potential intervention immediately preceding death rather than on death itself. Thus, CPR attains unwarranted symbolic importance. Even though almost all in the nursing home will die if CPR is performed, not performing it will result in certain death. It is sometimes difficult to let go of this small chance for life when hypothetically discussing CPR with patients and family members.

We should not be surprised that occasional conversations and even educational interventions do not easily inform or change opinions. We live in a culture in which the inevitability of death is denied as long as possible. That is not to say that we should stop trying to educate our patients. Education about CPR—what it is and its risks and benefits—may help. This information should be simply delivered and should be graphic and interactive. The process should include an elucidation of both patients' values and their comprehension of what they have been told. People also should be informed about advance directives and encouraged to name an agent to act with durable power of attorney for health care.

The well-controlled evaluation by Siegert and colleagues showed that one method did not enhance comprehension or result in more informed decisions. In their final paragraph, the authors make good suggestions for interactive as well as culturally and educationally appropriate strategies for communication. More realistic expectations of the value of CPR and, more important, a clear understanding that no matter what we do, we cannot prevent our own deaths, must permeate our culture. When this occurs, we and our patients will be better prepared for learning about and understanding advance directives. We will also likely make wiser decisions about our preferences for treatment.

we live in a culture in which the inevitability of death is denied as long as possible

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Clinical Pearl

Kidney stones: the combination of 16 mg of methylprednisolone and 40 mg of nifedipine per day is better than the use of steroid alone in encouraging passage of stones. The success rate is 87% compared with 65%. (*J Urol.* 1994;152:1095-1098.)

cians, could improve the frequency of their prevention-related counseling practices, and that women might be especially effective leaders in this effort.

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Clinical Pearl

For acute exacerbation of chronic obstructive pulmonary disease, magnesium sulfate (1.2 g over 20 minutes) improves peak flow (PF) (used with a β-agonist).

	PF at 0 min, L	PF at 30 min, L	PF at 45 min, L	Hospitalization Rate, %
Magnesium sulfate	137	162	161	28
Placebo	137	143	143	42

The difference in hospitalization rate was not statistically significant. (*Arch Intern Med.* 1995;155:496-500.)

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Clinical Pearl

Of magnetic resonance imaging scans of the shoulders of asymptomatic patients older than 60 years of age, 28% show full-thickness rotator cuff tears and 26% show partial rotator cuff tears. Of those of patients aged 40 to 60 years, 4% show full-thickness tears and 24% show partial tears. All patients with tears had osteoarthritis. Thus, be careful ordering magnetic resonance images of the shoulder—will it change management? (*J Bone Joint Surg Am.* 1995;77:10-15.)

cussed above demonstrate that an understanding of the origin of diabetes mellitus can make a difference in treatment.

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Clinical Pearl

The female condom: the 6-month pregnancy rate is 12.4%; the 12-month pregnancy rate is 22.2%. These rates are similar to other barrier methods. The rate of pregnancy was 3% at 6 months with perfect use. (*Am J Public Health.* 1994;84:1960-1964.)