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Marjorie A. Bowman, MD, MPA
Editor
Archives of Family Medicine

515 North State Street
Chicago, Illinois 60610

Internet Address
mbowman@mail.med.upenn.edu

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Dear Reader:

In an effort to provide you with a better learning experience, we are changing the frequency and format of *Archives of Family Medicine*. Effective with this issue, it will be published every other month (six times in 1997).

Because we are publishing the same number of pages as in 1996, you'll find that each issue is more robust. Paper stock of higher quality and an improved binding make the journal easier for you to read and refer to, again and again.

Our mission remains true: to be both clinically practical and academically sound. We seek to help physicians integrate the best new research into daily practice—through more effective diagnosis and treatment—leading to improved patient outcomes.

The American Medical Association remains firmly committed to our journal and to our specialty. Because family physicians play such a key role in caring for the public, and the demand for good science is greater than ever, we are continuing to develop *Archives of Family Medicine* into a better resource. Watch for a major new feature later this year.

I welcome your insight into how we can make the *Archives of Family Medicine* even more meaningful to you. Please feel free to e-mail suggestions to me at the following Internet address: mbowman@mail.med.upenn.edu.

Sincerely,

Marjorie A. Bowman MD.

Marjorie A. Bowman, MD, MPA

have had minimal efficacy, especially as typically applied to heterogeneous groups of patients with hypertension.[21] Hope still exists that as we better delineate the specific components of psychosocial stress, determining in the process the most pernicious and most amenable to change, we will become capable of supplementing our pharmacological approach with measures that not only lower blood pressure, but also prevent other ill effects and improve overall quality of life.

Thomas A. Barringer III, MD
Department of Family Medicine
Carolinas Medical Center
Charlotte, NC

Reprints: Thomas A. Barringer III, MD, Department of Family Medicine, Carolinas Medical Center, 1000 Blythe Blvd, Charlotte, NC 28203.

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Clinical Pearl

If the risk factor is temporary (such as surgery, estrogens, trauma, travel, Baker cyst, temporary immobilization, and pregnancy), then the recommended duration of anticoagulant therapy for first-episode phlebitis is 6 weeks. If the risk factor is permanent (such as systemic lupus erythematosus or venous insufficiency) or not known, the recommended duration is 6 months. With cancer or inherited thrombophilia, the anticoagulation therapy may need to be permanent. (*N Engl J Med.* 1995;332:1661-1665, 1710-1711.)

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Clinical Pearl

Mixed agonist/antagonist therapy (nicotine patch plus mecamylamine hydrochloride) is a new treatment for smoking cessation. One year later, 37% of the combination group had not smoked a cigarette, compared with 4% of the patch-only group. Mecamylamine therapy was started at 2.5 mg twice daily 2 weeks before and continued up to 5 mg twice daily 3 weeks after the patch was used. (*Clinical Pharmacol Ther.* 1994;56:86-97.)

Patients with anterior myocardial infarction but no pain have a worse prognosis (27% mortality at 2 years) than patients who had pain (13% mortality). (*Am J Med.* 1995;99:123-131.)

cantly hampered by the dermatopathologist who has to guess where and from whom the tissue originated. The patient's underlying diseases, if any, should be noted since many systemic illnesses display cutaneous manifestations. A list of the patient's medications, particularly when a biopsy of a suspected drug eruption is performed, is helpful and is mandatory if the patient is taking unusual medications (eg, immunosuppressants, anticoagulants, and other less common drugs).

DURATION

How long a lesion or eruption has been present influences greatly the differential diagnosis that the dermatopathologist will generate. A "red nodule on the arm" will trigger a vastly different differential diagnosis if it has been present for 1 day, 1 month, or 1 year.

DIAMETER

The size of a lesion is very important, particularly with pigmented lesions, since melanomas and nevi with architectural disorder (previously called dysplastic nevi) are usually greater than 6 mm in diameter.[9,10] Some clinicians "sample" larger lesions with, for example, a punch biopsy. If the whole of the lesion is not apparent to the examining pathologist, there is usually no way to know its true size. If, for no other reason, the size of any skin lesion should be recorded for insurance (and medicolegal) purposes. The record on a pathology report helps to make it "official." For cutaneous eruptions, this is less important, but the extent of the involvement should be made known. Skin diseases with a "geographic" configuration should include a comment on the lesional size.

DIAGNOSIS

The diagnosis may be the most important piece of information that is transmitted from the clinician to the dermatopathologist. What does the clinician think it is? If the clinician is totally stumped, as happens to all investigators, general categories of disease (papulosquamous, neoplastic, infectious, etc) will suffice. One should never be fearful of submitting an incorrect clinical diagnosis. A guess, even a wrong one, is better than no guess at all.

Physicians who submit tissue samples for evaluation have the right to clear, concise, timely, and helpful dermatopathology reports that are written in the language of clinical medicine. However, with this right, comes the obligation to provide the interpreting dermatopathologist with appropriate and accurate clinical information. Too often, clinicians who submit reports state that "I just didn't have time to write anything down" or "the nurse must have forgotten to fill that out." The time that is spent in providing the dermatopathologist with needed information on the transmittal forms constitutes a small fraction of that expended on the lesion as a whole but is usually crucial in its appropriate interpretation. In the long run, the few seconds that are expended on the transmittal of this information pays off with a better clinicopathologic experience for the clinician, the dermatopathologist, and, most important, the patient.

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Corresponding author: Alan S. Boyd, MD, Dermatology Department, 3900 The Vanderbilt Clinic, Nashville, TN 37232.

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Clinical Pearl

Hydroxyurea may help prevent painful sickle cell crises. (*N Engl J Med.* 1995;332:1317-1322.)

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Clinical Pearl

The use of benzodiazepines is associated with slower recovery from stroke. (*Neurology.* 1995;45:865-871.)