



ESTROGEN SUPPLEMENTS IN MENOPAUSE

■ *To the Editor:* In reading the article by Dr. Booher,¹ several comments and questions arose.

First, the 1983 US Health and Human Services Life Tables indicate a life expectancy of about 31 years for a 50-year-old woman. From what source did Dr. Booher obtain the life expectancy of 36 years for a 50-year-old woman and 39 years for a 52-year-old woman? Next, regarding the expansion of the population age 65 and older, most estimates predict a doubling by the year 2030 or 2050. What is Dr. Booher's source for the quotation of a doubling within the next 10 years? Also, Dr. Booher quoted the prevalence of vasomotor symptoms as 85%, whereas most sources find 50% to 60%. Finally, regarding the recommendation of the use of estrogen in breast cancer patients, does Dr. Booher have any data to support its safety in estrogen-receptor negative patients? Does he use estrogen in such patients in his own practice, and does he recommend it for others?

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1. Booher DL. Estrogen supplements in menopause. *Cleve Clin J Med* 1990; 57:154-160.

■ *Reply:* Life expectancy figures were obtained from a lecture presented by Dr. Lila Noctigal, New York University School of Medicine, at the menopause symposium conducted by Dr. Wulf Utian of Mount Sinai Medical Center (Cleveland) on September 12, 1986. I realize the error in predicted expansion of the number of women age 65 and older to double by the year 2000; this should have been by the year 2035.

Regarding vasomotor symptoms, my resource was Speroff.¹ I am sure the incidence varies depending on whether subjective or objective criteria are used.

The use of estrogen in women with a history of breast cancer is certainly a thorny issue, and I tend to be extremely conservative in this regard. However, a clinical management issue which has never seemed logical is that we have generally stopped performing

oophorectomy in most breast cancer patients. If endogenous ovarian estrogen is acceptable in breast cancer patients on tamoxifen, then exogenous non-oral ovarian estrogen should be equally acceptable. This point of view is supported by two sources.^{2,3}

On rare occasions, I do use estrogen in breast cancer patients with the collaboration and support of the breast cancer surgeon and medical oncologist. To be sure, the overall cost-benefit concept of menopausal management including cardiovascular disease, osteoporosis, and quality of life issues must be carefully evaluated, and meticulous informed consent with shared patient responsibility is essential. In discussing this with my colleagues, I recommend the same conservative approach.

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2. Notelovitz M. Noncontraceptive hormone therapy and breast cancer: a personal perspective of clinical guidelines. *Menopause Management* 1989; 2(3):5-8.
3. Weinstein L. Hormonal therapy in the patient with surgical menopause. *Obstet Gynecol* 1990; 75(4):47s-50s.

DIFFERENTIAL DIAGNOSIS OF HYPERSENSITIVITY VASCULITIS

■ *To the Editor:* I enjoyed the Highlight from Medical Grand Rounds article by Dr. Calabrese on hypersensitivity vasculitis.¹ In 1948, a landmark paper by Zeek and coworkers² separated periarthritis nodosa (PAN) from hypersensitivity angitis (HA) on the basis of morphological differences between these two angitides. In the ensuing years, this observation has been confirmed by many investigators. However, these criteria were not without criticism. In the early 1940s, Rich had restated the theory first suggested by Gruber, that PAN could occur in human beings as the result of a generalized hypersensitive reaction to some foreign agent, such as serum or sulfonamides. In 1958 Rich noted that Zeek and associates "have sought to differentiate their human cases of PAN that were clearly due to hypersensitivity from those in which no sensitization was apparent and which they term 'primary' PAN. I think I should say that our own experience, as

well as that of others, does not support the validity of the criteria."³ It is now clear that Rich's experimentally induced angitis more closely resembled Zeek's hypersensitivity angitis than PAN.

Born in 1899 in Ironton, Ohio, Dr. Zeek still maintains her interest in PAN. On June 4 she celebrated her 92nd birthday, and I invite all who benefit from her work to join me in sending her warmest wishes and many happy returns.

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1. Calabrese LH. Differential diagnosis of hypersensitivity vasculitis. *Cleve Clin J Med* 1990; 57:506-507.
2. Zeek PM, Smith CC, Weeter JC. Studies on periarteritis nodosa: differentiation between vascular lesions of periarteritis nodosa and of hypersensitivity. *Am J Pathol* 1948; 24:889-917.
3. Rich AR. Studies on hypersensitivity. *Can Med Assoc J* 1958; 78:163-170.

DRESSINGS FOR STASIS ULCER

■ *To the Editor:* I read with interest the article by Drs. Young and Terwoord¹ on a compression dressing system for stasis ulcer treatment, in the September 1990 issue. This is a very appealing and, no doubt, effective way to treat stasis ulcers. However, in an era of cost containment, the cost of this type of treatment seems excessive. In our area, the therapeutic stocking would cost \$44 or more if it were made to measure. The *Allevyn* 4 × 4 sterile dressings would cost \$57.50 for a box of six, and the *Intrasite* 4 × 4 sterile dressings would cost \$32 for a box of six.

It has been my habit for some time to use an alternative form of care which has been extremely effective. It was originally taught to me by Dr. Brownell Wheeler, Chief of Surgery at University of Massachusetts Medical School, and he learned it in England. The technique consists of a small amount of antibacterial ointment placed on the ulcer, covered with a Vaseline gauze or adaptic and, in turn, covered with a 3 × 3 gauze pad. Over this, a roll of Webril (cost, about \$1) is smoothly wrapped, and over this an Elastikon bandage (cost, about \$5.25). This dressing can be left on perfectly safely for a minimum of 2 weeks, even in the presence of a draining ulcer. I have had patients wear-

ing this kind of dressing for as long as 3 to 4 months without changing it. This, also, has proven to be perfectly safe.

I think this cost information should be brought to the attention of your readers.

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1. Young JR, Terwoord BA. Stasis ulcer treatment with compression dressing. *Cleve Clin J Med* 1990; 57:529-553.

■ *Reply:* Dr. Hill brings out a good point regarding the cost of the Jobst UlcerCare system when using *Allevyn* or *Intrasite* dressings.

Since the publication of our article in the *Cleveland Clinic Journal of Medicine*, we too have become concerned about the cost of the *Allevyn* and *Intrasite* dressings. In addition, a few patients have noticed some sensitivity reactions. Because of this, we rarely use these two dressings. Instead, we use normal saline dressings for infected ulcers. We still find the light white compression liner stocking very helpful in holding the dressings in place. It also enables patients to put on their heavy elastic stockings more easily.

The literature contains hundreds of ways to treat stasis ulcers. Dr. Hill's method is an interesting one, but I would be concerned about maceration of the skin when the drainage is excessive. In addition, the patient would also not be able to observe or bathe the leg while the dressing was on.

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ASPIRIN AND REYE'S SYNDROME

■ *To the Editor:* I write to protest at the misrepresentation of our study¹ in the article by Orlowski et al² and the editorial by Hurwitz and Mortimer³ in the July 1990 issue of the *Cleveland Clinic Journal of Medicine*. It was particularly unfortunate that the authors of the accompanying editorial did this, as our study findings support their views rather than refute them as they implied. We accept that our methodology was not as rigorous as that in the most recent US