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Apolipoprotein $\epsilon 4$ Homozygosity and Essential Hypertension

To the Editor: A 67-year-old Greek woman with a body mass index of 25 kg/m² was referred to the Lipid Clinic for dyslipidemia. She had stopped smoking 20 years previously, had been treated for hypertension for the past 10 years, and suffered a myocardial infarction 3 years prior. Her family history included stroke in her father at the age of 65, and hypertension in her son at age 47.

Coronary arteriography, performed 3 years before presentation, revealed 2-vessel disease. Percutaneous angioplasty and stent implantation of the right coronary artery followed. In addition, stenosis in peripheral arteries (60% of the right common carotid, 80% of the right renal [percutaneous implantation of stent was performed at age 65]), and diffuse stenosis of both femoral arteries were diagnosed by computed tomographic angiography. The patient's lipid profile without hypolipidemic treatment revealed a total cholesterol of 302 mg/dL, low-density lipoprotein cholesterol of 191 mg/dL, triglycerides 230 mg/dL, high-density lipoprotein cholesterol of 65 mg/dL, and lipoprotein (a) 40 mg/dL. The patient was treated with antihypertensive, hypolipidemic, and

conventional antiischemic drugs, and was followed up every 6 months on an outpatient basis for 4 years. She was very cooperative, walking every day for 20 minutes, had good control of blood pressure (120/80 mm Hg) and dyslipidemia (low-density lipoprotein cholesterol <100 mg/dL). Her body mass index remained stable. The patient was asymptomatic until January 2003, when she complained of angina on effort. A new coronary arteriography was performed and revealed 3-vessel disease. The patient underwent coronary artery bypass grafting. Definite and probable familial hypercholesterolemia was excluded based on criteria published by Hopkins.¹ Glucose loading test was negative and serum homocysteine level was normal. For this reason, and in light of our previous study,² the genotype that could influence coronary heart disease (CHD)—such as apolipoprotein E—was evaluated, and the patient was found to be homozygous for the $\epsilon 4$ allele.

Several studies have linked the $\epsilon 4$ allele with a greater risk of coronary heart disease. In a case-controlled study, among men aged less than 40 years who were referred for coronary angioplasty, the frequency of homozygotes for the $\epsilon 4$ allele was 16-fold higher than in healthy subjects.³ It was also reported that the $\epsilon 4$ allele could be an independent risk factor for death from coronary heart disease, and for nonfatal myocardial infarction.⁴ In addition, a trend for the $\epsilon 4$ allele to be associated with a higher prevalence of target organ damage in patients with mild to moderate hypertension has been proposed.⁵ Previously, we reported that the $\epsilon 4$ allele frequency among CHD patients was similar compared with healthy patients.² Greece belongs to those countries with a low $\epsilon 4$ allele frequency compared with other populations (10% versus 20–24%),² and this may explain the lack of association with CHD risk that we found. However, the presence of the $\epsilon 4$ allele, and particularly two of them in combination with hypertension and dyslipidemia, may be-

come more deleterious. Patients with two $\epsilon 4$ alleles may be candidates for even more aggressive treatment.

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Infective Endocarditis Due to *Providencia stuartii*

To the Editor: Infective endocarditis (IE) is a common and, if untreated, a uniformly fatal disease. The incidence of IE continues to rise, with a yearly incidence of about 15,000 to 20,000 new cases.¹ Moreover, the incidence of IE is about 1 per 1,000 hospital admissions, with infected patients having a mean age of 50 years.² The main pathogens are *Staphylococcus aureus*, *Viridans streptococci*, and *Enterococcus*.^{2–4} We describe a case of IE in a nursing home resident due to an uncommonly encountered agent, *Providencia stuartii*.

The patient was a 69-year-old male with a chronic indwelling Foley catheter who complained of subjective fever, chills, anorexia, and severe fatigue. He

was acutely ill, appearing emaciated, with a blood pressure of 78/40 mm Hg, heart rate of 90 bpm, respiration rate of 20 per minute and a temperature of 94.7°F. Heart and lung examinations were normal. Stage IV decubital ulceration was present on the left hip. White blood cell count was $18.6 \times 10^9/L$ (94.6% segmented neutrophils). Urinalysis was positive for leukocyte esterase, nitrates, and for leukocytes. Multiple and repeated sets of blood and urine cultures subsequently returned positive for *Providencia stuartii*. Transthoracic echocardiogram demonstrated an obvious, chaotic, oscillating mass on the mitral valve.

The diagnosis of endocarditis caused by *P stuartii* was based upon the presence of two of the Duke major criteria⁵ of persistent bacteremia separated by greater than twelve hours and an oscillating mass on the mitral valve. Although the presence of *P stuartii* is well documented in urine samples of patients with chronic indwelling catheters, and in surgical wounds, feces, blood cultures in nursing home patients, water samples, burn units, and even in pediatric sepsis cases, the occurrence of endocarditis due to this pathogen has not been reported to our knowledge.

According to the current classification, there are five species in the genus *Providencia*⁵, namely *P alcalifaciens*, *P heimbachae*, *P rettgeri*, *P rustigianii*, and *P stuartii*. The medical significance of *P stuartii* has usually been confined to nursing home patients with a chronic indwelling bladder catheter. Bacteria seldom considered to be uropathogens in noncatheterized patients are found commonly in the urine of long-term-catheterized patients. *P stuartii* is a classic unfamiliar pathogen that occurs frequently in the urine of patients with a chronic indwelling catheter.

In summary, while the endocarditis-associated classic Gram negative bacteria, HACEK (an acronym that refers to *Haemophilus* species, *Actinobacillus actinomycetemcomitans*, *Cardiobacterium hominis*, *Eikenella corrodens*, and *Kingella* species) and *Pseudomonas aeruginosa* have been well documented, the

emergence of *Providencia stuartii* as a source of endocarditis has not been established. Given the frequency of its appearance in the urine samples of nursing home patients, particularly those with chronic indwelling catheters, perhaps the incidence of this pathogen causing endocarditis is higher than otherwise thought. The endocarditis could be easily missed in elderly patients due to their inability to mount a febrile reaction, difficulty obtaining a history, and perhaps the attribution of a murmur to a chronic cardiac condition. Moreover, the overall constellation of signs and symptoms could easily be assigned to urosepsis.

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Antenatal Diagnosis of an Extrahepatic Portal Vein Aneurysm

To the Editor: We are writing to report an infant antenatally diagnosed with an extrahepatic portal vein aneurysm. A healthy 30-year-old female underwent an antenatal sonogram at 34 weeks' gestation. A large flowing vessel was noted near the midline, in proximity to the caudate lobe of the liver. Following an otherwise unremarkable

pregnancy, a boy weighing 3,145 g was born via repeat cesarean section at 39 weeks' gestation. At birth, the physical examination was normal. Physiologic jaundice resolved without treatment. An abdominal sonogram performed on the first day of life showed a portal vein aneurysm at the junction of the splenic and superior mesenteric veins measuring 1.5×0.8 cm, with venous flow confirmed by color flow and duplex Doppler sonography. The infant underwent a follow-up study at one month and at one year, showing no change in the size of the aneurysm. The child remains asymptomatic.

Portal vein aneurysms are rare anomalies of unknown etiology. Since being first described in 1956, fewer than 60 cases have been reported.¹⁻³ The cause of portal vein aneurysms remains controversial, with proposed etiologies including a developmental anomaly, congenital weakness of the venous wall, or acquired weakening of the vessel due to portal hypertension or inflammation.⁴ In the absence of an apparent acquired post-natal cause such as weakening of the portal vein vessel due to inflammation or portal hypertension, cases of aneurysmal dilation of the portal vein have been attributed to a venous anomaly related to abnormal development.

Normal splanchnic venous development provides insight into the potential developmental anomaly that may lead to these aneurysms. The portal vein develops from the paired vitelline veins and their communications. Three anastomoses form between the right and left vitelline veins by the fourth week of gestation. The most cranial is located at the porta hepatis, the middle in a retroduodenal position, and the most caudad distal to the origin of the common bile duct. The portal vein forms from the most cranial portion of the right vitelline vein, the middle anastomosis, and the caudad portion of the left vitelline vein following regression of the remaining portions of the venous plexus. The most common sites for portal vein aneurysms are at the confluence of the splenic and superior mesenteric veins (as was found in the pa-

tient in the current report), in the main portal vein, and in the intrahepatic portal vein at branching sites.⁵ Incomplete regression of portions of the vitelline veins and their anastomoses may account for portal vein aneurysms observed at these locations.

The current case supports a possible developmental defect as the cause of portal venous aneurysms first identified in older children and adults.

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Problems with Subjective In-training Evaluations

To the Editor: How does a program assess the clinical performance of physician trainees? In-training evaluations (ITEs) were created for this purpose.¹ ITEs should be based on training objectives, recent faculty observations, and reflect a fair and equitable process. However, most ITEs are subjective¹ and can thus be subject to many kinds of bias.²⁻⁴ Faculty may also have difficulty in providing negative evaluations—particularly if they have experienced a complaint regarding their past evaluations.

We would like to recount our experience with ITEs. We employed a comprehensive system of training objectives with a six-point grading scale: “unacceptable,” “needs to improve,” “acceptable,” “good,” “above average” (better than 60% of residents), and “outstanding” (better than 95% of residents). Initially, individual faculty performed each ITE. A review of 50 consecutive ITEs revealed the majority of evaluations to be “good” or “above average,” whereas only rarely was performance deemed “unacceptable” or “in need of improvement.” Moreover, we dispensed “outstanding” grades at twice the defined frequency.

There were other problems. Two residents complained that they had been unfairly underrated. One resident, who never had been evaluated at less than “acceptable,” was identified by written comments from a single ITE to have major deficiencies that, in retrospect, had been overlooked on prior evaluations.

In an attempt to minimize bias, committees comprised of three faculty performed all further evaluations. With this reform, “acceptable” grades were dispensed about twice as frequently as before, “good” grades were given 30% more frequently, whereas “above average” and “outstanding” grades were granted about half as often. Some faculty, however, expressed the view that “outstanding” grades should be dispensed more liberally, as an encouragement and reward. In addition, about half of the trainees complained that the expectations placed on their performance were unrealistic. Some trainees attempted to have their evaluations upgraded or to avoid rotations with faculty they perceived to be more stringent.

Our system of graded objectives seemed inefficient in identifying residents in need of help. Written and verbal comments offered by individual faculty were often more informative, and despite the predominance of excellent grades, such comments were made frequently. We felt unable to act upon verbal comments alone, as these had been provided without the controls requisite to ITEs.

We encountered two different eval-

uation approaches. With a laissez-faire approach, above-average evaluations would be dispensed liberally; the national examination boards would then ensure physician competence. Under a more stringent approach, the majority of evaluations would be “satisfactory,” and the strengths and weaknesses of individual trainees would be identified and corrected before board examinations.

The stringent approach might best address the educational needs of trainees. But, as we had observed, it was difficult to control mark inflation, and this approach was unpopular. We concluded that it was unrealistic to utilize a subjective grading scale any more discriminating than “pass” or “fail.” To circumvent many of the problems we experienced, there was a need for objective, structured clinical examinations to supplement or replace our subjective evaluations.

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Dermatitis Artefacta in a Patient with Recurrent Larynx Cancer: A Rare Self-inflicted Dermatosi

To the editor: Dermatitis artefacta is one of the self-induced dermatological disorders, which is also referred to as a

variant of the obsessive-compulsive disorder.¹ Although it is a rare disorder, the lesions may be reminiscent of various dermatoses.²

A 51-year-old male was diagnosed with locally advanced supraglottic larynx cancer, and total laryngectomy and left radical neck lymph node dissection was performed 4 years prior. Radiotherapy was also applied postoperatively. The patient was in remission until recurrent lesions appeared on the neck region, and were confirmed by fine needle biopsy as squamous cell carcinoma. Chemotherapy was started. During his hospital stay, excoriative erosive cutaneous lesions on the chin, the interscapular area, and on the dorsal side of his legs were observed in routine physical examination (Fig. 1). On delicate follow-up, it was realized that the lesions were made by the patient himself. Later, the patient and his wife did also confess that the lesions were self-inflicted. Thus eventually the diagnosis of dermatitis artefacta was established. Accordingly, he was treated with anxiolytics and antidepressants, whereupon the lesions disappeared.

Dermatitis artefacta is a rarely encountered factitious disease with wide-ranging morphologic features. It is a psy-

chogenic, self-inflicted syndrome, the lesions of which resemble trichotillomania, neurotic excoriations, and Münchhausen syndrome. Although our patient is male, dermatitis artefacta is a female-predominant psychocutaneous syndrome.¹ It can be seen at any age, although adolescents and young adults are by far the most frequently affected.³ The lesions in dermatitis artefacta are various, and include vesicles, erosions, ulcers, abrasions, purpura, erythema, and nodules.⁴ It thus entails the following differential diagnoses: contact dermatitis, Koebner reaction, lichen striatus, lymphangitis, pemphigus, pemphigoid, porphyria cutanea tarda, staphylococcal impetigo, basal cell carcinoma, vasculitis, sensory nerve lesions, excoriations due to scabies, pediculosis, and eczema. The causes of the lesions are also various. Excoriation and chemical or thermal burns are some of the methods used by the patient.⁵

Diagnosis is made by way of vigilant evaluation of the patient's affect, personality, and medical history,⁴ and by exclusion of the other likely pathologies. Self-inflicted injury can also be detected by using systems with cameras and mirrors.² Innocent smile, ob-

sessive care for the lesion, and also enjoying the prediction of the appearance of a new lesion are the other noteworthy clues.

There are both medical and nonmedical therapeutic approaches to dermatitis artefacta. The nonmedical approach starts with supportive and empathic contact with the patient, rather than direct confrontation.² Protective dressing may be another option. Antianxiety and antidepressant drugs are sometimes used.⁴ When the patient starts to rely on the physician and a stable patient-doctor relationship is established, a treatment such as psychotherapy can be commenced. It is commonly accepted that a positive change in the psychosocial life conditions of the patient is generally more successful than a medical treatment.

This rare case of ours suggests that such a complication may be seen in cancer patients in addition to the debilitating impact of their malignancy.

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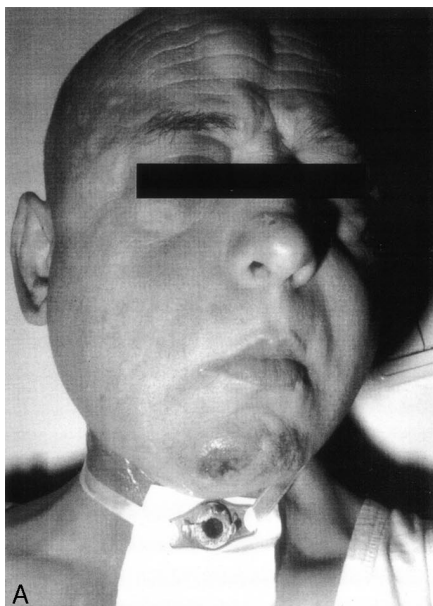
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Excoriative erosive cutaneous lesions on the chin (A) and the dorsal side of the patient's legs (B).