and should be considered frontline agents in medical decision making with such patients.

Caplan does have valid points in his editorial. ED physicians do not always perform a thorough neurological examination. For example, assessment of gait is often overlooked or impractical among patients in the hallway of a crowded ED. This issue can be easily addressed. The neurological education of emergency medicine residents could be improved. This is a factor to consider in curriculum development, although not all neurology rotations are of equal value, as pointed out in the article by Caplan and Adelman about the state of neurological education. (Neurology curricula for internal medicine, obstetrics/gynecology, and family practice residencies were also deemed inadequate in that article.)

Despite these issues, Caplan’s opinions in his editorial are simply opinions—they are not supported by the literature cited. The editorial represents the voice of a single physician who has drawn erroneous conclusions to support his political viewpoint.

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In reply: Misdiagnosis in patients with acute neurological and cardiac presentations can be disastrous. Rapid action is often needed to preserve brain function. Neurological problems are complex and diverse, and the time to analyze the situation and then act is short. These facts make acute neurological emergencies extremely difficult to manage optimally, even by well-trained and experienced physicians.

The letters in response to my editorial argue that evidence for suboptimal management of neurological urgencies in emergency departments (EDs) is poor. I agree fully. This issue is very difficult to study scientifically. A controlled trial of management by emergency physicians vs hospitalist neurologists would be difficult, especially in nonurban environments, and would be unethical. Reviewing the outcomes and management of all neurological patients seen in the ED by both emergency physicians and neurologists for quality assurance would also be difficult to accomplish. My experience in seeing thousands of patients after their acute neurological management in EDs and in discussions with colleagues—emergency physicians, internists, and neurologists throughout the United States—enforces the general belief that often acute neurological emergencies are not handled optimally in EDs with resultant serious injuries to patients. If the letter writers doubt this, I invite them to survey emergency physicians (at academic, urban nonacademic, and rural hospitals) to gauge their confidence in managing neurological emergencies.

My intent in discussing this issue in Mayo Clinic Proceedings was to call attention to the problem, not to throw stones at any group. As I stated in my editorial, the job of an emergency physician is among the most difficult of any physician. Much of the responsibility for suboptimal ED care of neurological patients lies with neurologists. Many neurologists have a predominantly outpatient office practice away from the hospital and are not anxious to come emergently to EDs, especially for problems they are uncomfortable managing. Far too few neurologists are trained to care for acute central nervous system conditions.

Recognizing and admitting that a problem exists is the first step toward ameliorating it. The possible solutions are many.

1. More neurological training for emergency physicians by experienced hospitalist neurologists is needed. This must include hands-on case experience, not just didactic sessions.
2. In large urban hospitals, some subspecialization among emergency physicians is necessary, in which some obtain more training and experience in neurology and some develop other subspeciality interests. As medicine and technology have become more complex, all specialties have become much more subspecialized.
3. More teams of emergency physicians and neurologists are needed to treat ED patients. With this strategy, many emergency physicians would be able to manage neurological urgencies.
4. More neurologists and internists need to be trained to manage neurological urgencies (have hospitalist neurologists available at the ED). More telemedicine with connection to on-call neurologists experienced in urgent care would be helpful. Emergency physicians, neurologists, internists, and hospital administrators must acknowledge that there is a problem and must work together to solve it. Little is to be gained by denying that a problem exists.

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CORRECTION

Incorrect wording: In the article by Yawn et al entitled “A Population-Based Study of the Incidence and Complication Rates of Herpes Zoster Before Zoster Vaccine Introduction,” published in the November 2007 issue of Mayo Clinic Proceedings (Mayo Clin Proc. 2007;82(11):1341-1349), the 2nd sentence under the heading “Incidence of HZ” on page 1344, left-hand column, contained incorrect wording. The sentence should read as follows: The age-adjusted, sex-specific rates extrapolated to the US population are higher in women than in men (3.9 vs. 3.2 per 1000 person-years, respectively; P<.001) and increase with age.