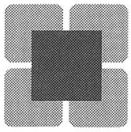

DAVID L. LONGWORTH, MD, AND JAMES K. STOLLER, MD, EDITORS

Internal medicine update

TUBERCULOSIS: INCREASED INCIDENCE DEMANDS ATTENTION

The last 6 years have seen a steady increase in the incidence of tuberculosis as a result of the AIDS epidemic, an upsurge in the number of infected immigrants, the increased use of immunosuppressive drugs, and the aging of the general population. The Centers for Disease Control recently updated the guidelines for interpreting tuberculin skin tests. An induration of 5 mm at 48 hours to a properly placed 5TU-PPD is positive and worthy of isoniazid prophylaxis if the chest radiograph is compatible with old tuberculosis, if the patient has had contact with smear-positive patients, and if HIV or some other immunosuppressive disease is present. An induration of 15 mm is considered positive if none of these risk factors is present. Most cases can be treated successfully by general internists; isoniazid remains a reasonably safe and effective prophylaxis, despite recent reports to the contrary.

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RISK OF HEPARIN-INDUCED THROMBOCYTOPENIA

Heparin-induced thrombocytopenia (HIT) occurs in approximately 3% to 8% of patients who receive heparin. It is related to a heparin-dependent antibody, and while it is most common in patients receiving standard therapeutic doses of heparin, it may be seen in patients receiving much lower doses.

Platelet counts should be monitored during heparin therapy. Should HIT be suspected, a test to detect heparin-dependent platelet antibodies by means of platelet aggregometry may be performed.

The treatment of HIT consists of discontinuing the heparin and substituting alternative forms of anticoagulation. If "white clot" syndrome has developed, these clots may be removed with intraarterial catheters or fibrinolytic therapy.

If systemic intravenous anticoagulation is needed in a patient with a history of HIT, the use of the defibrinating agent ANCROD may be considered.

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IS RIGOROUS GLYCEMIC CONTROL WORTHWHILE?

Although efforts to achieve rigorous glycemic control in type I diabetic patients is expensive and labor-intensive, ongoing research suggests it is worthwhile. The clearest evidence of benefit is in diabetic patients who are pregnant: good glycemic control at the time of conception reduces the risk of congenital abnormalities. During pregnancy, good control also lowers the risk for spontaneous abortion and perinatal mortality. Animal data suggest that rigorous control improves kidney histology. Other data point to a positive effect on retinopathy, though patients with existing complications may be less likely to benefit. No one yet has confirmed that tight blood sugar control reduces the risk for macrovascular complications, but the association between good control and improved lipid profiles supports this notion.

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Highlights from The Cleveland Clinic Foundation's continuing medical education course, "Intensive Review of Internal Medicine." Drs. Longworth and Stoller were course co-directors.

THYROID NODULES: WHICH SHOULD BE TREATED?

Thyroid nodules are very common—occurring in 5% to 10% of patients on physical examination. Yet the vast majority are benign and require no intervention unless the size causes cosmetic or pressure problems. When working up a nodule and thyroid tests are normal, the best diagnostic strategy is fine-needle aspiration biopsy. Radioactive iodine uptakes, various imaging scans, and ultrasound add to the cost with little diagnostic benefit. Suspicious lesions should be operated on—about 30% will be cancerous. Clinically, enlarged lymph nodes in conjunction with an isolated nodule indicate malignancy. Suppression of nodules via hormonal therapy is ineffective; one ultrasound study showed that patients followed for 6 months had no decrease in nodule size.

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Correction

An error occurred in the Radiology Pathology Grand Rounds article entitled "Pelvic retroperitoneal mass in a 36-year-old man," published in the July/August issue of the *Cleveland Clinic Journal of Medicine* (1992;59[4]:429-433). On page 432, the arrow marker on Figure 7 should have been deleted, and the words "...A cleaved nucleus is visible...which could represent new mitosis" should have been deleted from the legend. The corrected figure and figure legend are printed below:

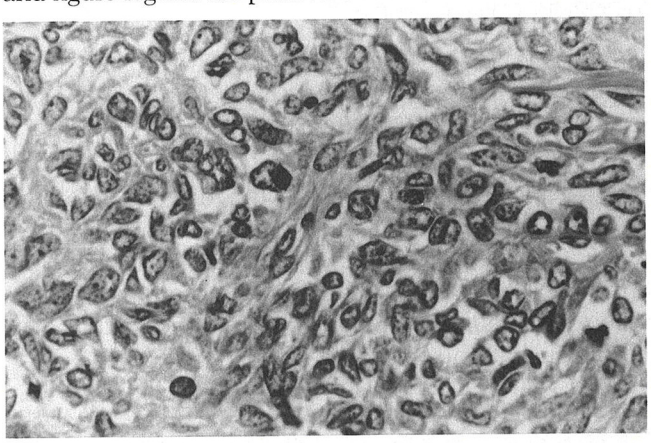

FIGURE 7. Photomicrograph showing hypercellularity, marked nuclear pleomorphism, and indistinct cytoplasmic borders (hematoxylin and eosin, ×550).