As the premier scholarly publication of the osteopathic medical profession, *JAOA—The Journal of the American Osteopathic Association* encourages osteopathic physicians, faculty members and students at colleges of osteopathic medicine, and others within the healthcare professions to submit comments related to articles published in the *JAOA* and the mission of the osteopathic medical profession. The *JAOA*'s editors are particularly interested in letters that discuss recently published original research.

Letters to the editor are considered for publication in the *JAOA* with the understanding that they have not been published elsewhere and that they are not simultaneously under consideration by any other publication.

All accepted letters to the editor are subject to editing and abridgement. Letter writers may be asked to provide *JAOA* staff with photocopies of referenced material so that the references themselves and statements cited may be verified.

Readers are encouraged to prepare letters electronically in Microsoft Word (.doc) or in plain (.txt) or rich text (.rtf) format. The *JAOA* prefers that letters be e-mailed to jaoa@osteopathic.org. Mailed letters should be addressed to Gilbert E. D'Alonzo, Jr, DO, Editor in Chief, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611-2864.

Letter writers must include their full professional titles and affiliations, complete preferred mailing addresses, day and evening telephone numbers, fax numbers, and preferred e-mail addresses. In addition, writers are responsible for disclosing financial associations and other conflicts of interest.

Although the *JAOA* cannot acknowledge the receipt of letters, a *JAOA* staff member will notify writers whose letters have been accepted for publication. Mailed submissions and supporting materials will not be returned unless letter writers provide self-addressed, stamped envelopes with their submissions.

All osteopathic physicians who have letters published in the *JAOA* receive continuing medical education (CME) credit for their contributions. Writers of original letters receive 5 hours of AOA category 1-B CME credit. Authors of published articles who respond to letters about their research receive 3 hours of category 1-B CME credit for their responses.

Although the *JAOA* welcomes letters to the editor, readers should be aware that these contributions have a lower publication priority than other submissions. As a consequence, letters are published only when space allows.

Chronic Musculoskeletal Dysfunction After Massive Weight Loss

To the Editor:

Gastric bypass surgery (GBS) has been shown to reduce body weight effectively,[1] and use of this procedure is markedly increasing in the United States.[2] As more and more patients undergo GBS, our heightened cognizance to the postsurgical care of these patients is required.

Among many medical concerns I have for post-GBS patients is an incidental finding I noticed recently during an in-depth patient review for a separate study. In examining the medical records of post-GBS patients, I observed that a rather large percentage of these patients complained of various musculoskeletal issues—most commonly, chronic back pain.

Massive weight loss can result in ptosis of the breasts and excessive laxity of the skin around the arms, back, flanks, abdomen, and proximal legs, which may be causative factors in these complaints.[3] Hooper et al[4] concluded that patients' musculoskeletal complaints significantly decrease after GBS when compared with their status before surgery. From an osteopathic perspective, it is likely that these patients develop chronic somatic dysfunctions while morbidly obese, and that although they experience dramatic improvement in their symptoms after GBS, there continue to be musculoskeletal issues secondary to the severe ptosis and weight of the excess skin.

Body contouring surgeries are available to treat these areas of ptosis[5–7] and may also help to reduce these musculoskeletal complaints. Hurwitz[8] has recently shown that it is possible to safely help patients who have undergone massive weight loss with a single-stage surgical procedure called the total body lift (TBL), which removes sagging skin of the upper and lower body and contours these areas into a healthier-looking shape.

If the chronic nature of a patient's preoperative low back pain extends into the later postoperative period, however, he or she may benefit from osteopathic manipulative treatment (OMT). A recent meta-analysis of randomized controlled trials, which studied the efficacy of OMT for the treatment of low back pain, concluded that OMT results in a significant reduction of pain.[9]

Although I have only briefly touched on my perspective regarding this recent observation, I hope that I have motivated readers to take an interest in the musculoskeletal health of post-GBS and post-TBL patients. It would be interesting to see the results of a longitudinal study that focuses specifically on osteopathic diagnoses pre-GBS, post-GBS, and post-TBL. Additionally, a cohort study of post-GBS and post-TBL patients—divided into an

Editor's message: In the original print publication, there was an error in terminology in the letter by Roy R. Reeves, DO, PhD. In the middle column, first sentence in the first full paragraph, "American Board of Medical Specialties" was intended instead of "Accreditation Council for Graduate Medical Education." The error has been corrected here.

OMT group and a non-OMT group—may demonstrate the efficacy of OMT in the musculoskeletal health of these types of patients.

Adding osteopathic evaluation to the care of post-GBS and -TBL patients should be considered, as these patients may have compensating spinal, muscular, and peripheral joint dysfunctions that would need adjustment to respectively promote appropriate posture, strength, and motion for their new body habitus. Such involvement of multiple disciplines of medicine ensures a well-rounded approach to patient care.

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AOA Certifying Boards Are Credible and Capable

To the Editor:

I read with great interest the letter by George Mychaskiw II, DO, in the May 2006 issue of *JAOA—The Journal of the American Osteopathic Association* regarding his concerns about the current status of osteopathic graduate medical education ("Will the last DO turn off the lights?" 2006;106:252–253, 302). Being myself in a situation not dissimilar to that of Dr Mychaskiw, I feel compelled to relate my personal observations of some of the issues brought up in his letter.

Regarding the validity of American Osteopathic Association (AOA) board certification, Dr Mychaskiw concludes that the opinion held by some MDs that AOA certifying boards are " 'easier' and less credible" than American Board of Medical Specialties boards may be accurate. My own experience leads me to reach quite a different conclusion. My residencies in psychiatry and neurology were completed in allopathic programs and were approved by the AOA, so I was able to obtain certification in these fields by both the American Board of Psychiatry and Neurology (ABPN) and the American Osteopathic Board of Neurology and Psychiatry (AOBNP). I found the AOBNP examinations similar in content to—and at least as difficult as—the ABPN examinations in both psychiatry and neurology. In fact, for me, the AOBNP Part 2 oral examination in neurology was actually more difficult; I had to repeat this examination a few times to successfully complete it. (That was not my experience with the corresponding ABPN examination.) Thus, I believe that AOA certifying boards are fully capable of maintaining appropriate standards for certification.

Unfortunately, Dr Mychaskiw's observation that AOA board certification is not universally accepted in the allopathic academic community does appear to be true. The allopathic medical schools with which I have had experience do not recognize certification by AOA boards, regardless of how good the training is in the AOA-approved residency programs. I believe this is probably true with allopathic schools in general. This lack of recognition creates a possible dilemma for some DOs who enter postdoctoral training programs wishing to pursue a career in academic medicine.

Fortunately, there are a few signs that attitudes against osteopathic boards may be beginning to change. The number of DOs on faculty in allopathic schools I am familiar with has increased notably over the past 15 years. In addition, one can now frequently see authors with DO degrees in scientific and medical journals, and articles in the *JAOA* are cited in the National Library of Medicine's Index Medicus. Furthermore, many federal organizations, including the US Department of Veterans Affairs, recognize AOA board certification. At this point, however, a physician cannot use AOA board certification alone to procure a faculty position with most allopathic training programs.

The number of DOs in allopathic residency programs continues to climb.[1] It appears that the MD community has reached the point of accepting the fact that the colleges of osteopathic medicine can adequately train students to become qualified physicians. Hopefully, with time, osteopathic graduate medical education and board certification by AOA programs (which can be educationally equal to, and just as difficult as, ACGME programs) will be fully accepted as well.

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Response

I very much appreciate Dr Reeves' thoughtful comments regarding my letter in the May 2006 issue of *JAOA—The Journal of the American Osteopathic Association*.[1] I am pleased to know that his experience with the American Osteopathic Board of Neurology and

Psychiatry has been favorably different from my experiences with the American Osteopathic Board of Anesthesiology. It is not unreasonable to expect that there will be substantial variation among the American Osteopathic Association (AOA) specialty boards, especially given the low numbers of physicians certified by these boards in some specialties.[2] In this regard, the standards of the member boards of the American Board of Medical Specialties (ABMS), the organization that represents allopathic medical specialty boards,[3] may be more consistent than those of the corresponding osteopathic boards—simply because of the large number of allopathic physicians in practice.

Unfortunately, it is nearly impossible to definitively answer the question of osteopathic vs allopathic specialty board quality, because no systematic head-to-head comparison has ever been performed. Thus, we are left with anecdotal reports, including those illustrated by Dr Reeves and me.

The large number of allopathic residency positions, coupled with a dwindling number of osteopathic hospitals and fewer filled osteopathic residency positions, makes the ABMS certification the de facto standard.[4–6] Dr Reeves is quite correct that sole osteopathic board certification may be a hindrance in the allopathic academic world. Even more disturbingly (based on personal communications I've had with leaders in many allopathic medical schools), the DO degree—in and of itself—is a hindrance in an academic career. These attitudes are changing and not universal among allopathic institutions, but the tiny number of DOs who are department chairs or deans in allopathic medical schools testifies to the veracity of the generalizations.

Following the publication of my letter in the May 2006 *JAOA*, I was gratified to receive numerous letters from DOs around the United States expressing solidarity with and support of my views. Most of these letters were from specialists and subspecialists in such areas as pediatric neurosurgery, histopathology, and neurology. To a one, they all expressed doubts about osteopathic graduate medical education (OGME) and certification, frustration with the AOA and the "official" osteopathic world, and a deep support for and belief in osteopathic medicine, despite the fact that few of them practice osteopathic manipulative treatment (OMT) in their practices.

The strength and future of the osteopathic medical profession lie in the continued undergraduate education of competent, caring, and superior osteopathic physicians. A cadre of highly trained specialists and subspecialists is essential in this endeavor. We cannot, nor should we even try to, compete against the programs in massive allopathic medical centers that have large patient volumes, sophisticated and expensive technologies, and substantial research funding. Rather, I believe we should encourage graduates of colleges of osteopathic medicine to enter these allopathic programs. These student DOs could then go on to demonstrate the quality of osteopathic medical education, pass the ABMS boards, and return to the AOA and the osteopathic medical profession, making us all stronger in the process. In the specialties beyond primary care, it is difficult to make a case for the existence of separate osteopathic board examinations.

I have corresponded with John A. Strosnider, DO, the current president of the AOA, about these matters. I am once again calling on the AOA to open a dialogue with osteopathic physicians who have trained in and function in the allopathic world. We support our profession and its philosophy—not for political reasons—but because it represents good patient care. But we need to do a better job in letting the general public know that we are not just family doctors, but also pediatric cardiac anesthesiologists, neurosurgeons, histopathologists, and cardiologists.

The May 20, 2006, cover of *Newsweek* magazine featured a photograph of Richard Jadick, DO, with the huge, blaring title, "He Saved 30 Lives in One Battle—Hero M.D.—The Amazing Story of the [Iraq] War's Most Fearless Doctor."[7] Of course, the title should have read, "Hero D.O." Although *Newsweek* got his medical degree wrong, Dr Jadick stands as an example of the strength and future of osteopathic medicine. When Dr Jadick conducts battlefield surgery in Iraq, he is not using OMT, but he is still practicing osteopathic medicine. Similarly, when I administer anesthesia to a neonate undergoing surgery for hypoplastic left heart syndrome or when my DO neurosurgical colleague is clipping an aneurysm, we are not using OMT but we are still practicing osteopathic medicine. Isn't it finally time for us to all come together?

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AOA Needs to Reach Out More

To the Editor:

I read with interest the comments by Kenneth J. Steier, DO,[1] and George Mychaskiw II, DO,[2] in their separate letters in the May 2006 issue of *JAOA*—

The Journal of the American Osteopathic Association. I agree with their expressed concerns about osteopathic graduate medical education, board certification, and the future of osteopathic medicine. The attempts by Drs Steier and Mychaskiw to provide "outside" information—by virtue of their allopathic affiliations—to American Osteopathic Association (AOA) constituents capable of effecting changes in policy should serve as a wake-up call.

As an allopathically trained surgical epileptologist specializing in the surgical treatment of patients with refractory epilepsy, I practice within a unique setting of both subspecialty private practice and academic affiliation. I support the AOA and understand the attempts to maintain a distinct and separately recognized professional organization. Yet, I feel that the AOA is not reaching out to those of us who have close affiliations with an allopathic environment.

Qualified osteopathic training programs for the primary care physician have been available for years. However, specialty training is more readily available from the greater number of allopathic institutions, which are capable of providing more opportunities within an individual's selected field of expertise than are osteopathic institutions. As such, more osteopathic physicians will be seeking separate board certification from allopathic credentialed boards after their training. Most allopathic residency directors (and fellowship directors) are inclusive of graduates of colleges of osteopathic medicine, by virtue of the osteopathic, patient-centered philosophy that characterizes our graduates.

Beyond the community hospital setting that provides many DOs with training, osteopathic manipulative treatment (OMT) will hopefully remain a part of osteopathic philosophy, regardless of whether we as individual osteopathic physicians use it. The use of OMT as a cornerstone to every treatment is difficult to substantiate when rigorous scientific methodology is applied.[3] However, by focusing on valid scientific paradigms (ie, literature review[4] and controlled clinical trials[5]), OMT may become more universally accepted as a useful *adjunct* to physical medicine.

It is imperative for those of us who have moved on to higher levels of specialty or subspecialty education to promote favorable public relations for these osteopathic physicians who will follow, regardless of their individual clinical or academic pursuits. We are ultimately judged not as "DOs," but by the knowledge and actions that we apply to help our patients. As a group, we must be inclusive and actively continue to pursue the involvement of *all* DOs—irrespective of their training, practice affiliation, or board certification. As individuals, we must participate to strengthen the AOA, our primary organization, if our profession is to evolve and prosper.

As more osteopathic physicians choose not to take the osteopathic pathway for specialty education, it is up to the AOA to reach out to the many who are fading away and not dismiss them because they "have chosen not to partake of the many benefits that the AOA has developed for them."[6]

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Establishing a Case for Cause and Effect

To the Editor:

After reading the recent case report by David G. Lancaster, DO, and Thomas Crow, DO, "Osteopathic manipulative treatment of a 26-year-old woman with Bell's palsy," which appeared in the May 2006 issue of *JAOA—The Journal of the American Osteopathic Association* (2006;106:285–289), I find it necessary to address a few critical clinical points.

Although Bell's palsy can affect 0.02% of the population, most cases are mild to moderate, with an average recovery period of several days to a few weeks.[1] Severe cases may take months to resolve, and in rare instances may result in permanent impairment. There seems to be an increased chance of Bell's palsy in patients with advanced age, autoimmune disorders, diabetes mellitus, and pregnancy. The most important clinical considerations are: (1) to protect the involved eye from desiccation and (2) to assess the patient for ear and mastoid process infections, intracranial mass, stroke, or other related pathologic conditions, such as autoimmune disorders, HIV (human immunodeficiency virus) infection, Lyme disease, and sarcoidosis.[2]

Lancaster and Crow, citing another study, state "osteopathic physicians commonly find restricted ipsilateral motion of the temporal bone and upper cervical restrictions in patients with Bell's palsy." I find this statement ludicrous. In my 12 years of clinical practice (including about 18 months of neurology as part of a physical medicine/rehabilitation residency program of a large Baltimore hospital system), none of the 15 to 20 patients I have seen with Bell's palsy displayed these signs. It is

also difficult to agree with the authors' conclusion that "…enhancement of lymphatic circulation resulted in the complete relief of the patient's unilateral facial nerve paralysis within 2 weeks…." How were the lymphatic circulation and the effects of "…osteopathy in the cranial field…to balance the tension membranes and to promote symmetry in the temporal bone and sacral motion" measured in this particular case?

It seems much more likely that the patient described in the report had a mild case of Bell's palsy, which, like most, resolved within a few weeks. It is important to recognize that just because "B" follows "A," one cannot conclude that "B" is caused by (or is the result of) "A."

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