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Letters to the Editor

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[Case Report: Exposure to Parvovirus B19 Presenting as Acute Arthralgia](#) *F. Ariella Baylson, and Fred W. Markham, Jr., M.D.*

[Health Problems Associated with Exposure to Pesticides](#) *Luke Curtis, M.S.*

[Maneuver to Deliver Newborns with Shoulder Dystocia](#) *Neal Devitt, M.D.*

[Case Report: A Movement Disorder Related to Use of Oxycodone](#) *James Grebosky, M.D.*

Use of Abbreviations in American Family Physician

TO THE EDITOR I have read *American Family Physician* for a long time. I am basically retired and wonder if I am so far behind the times that I am the only one having trouble with all the articles that use abbreviations for words? In many articles, it becomes confusing to me, and I believe it shows only laziness on the part of the authors and editors. How many extra letters and or lines would be used to properly identify what one is saying? I would guess in all the articles combined it would add less than one fourth of a page.

Wouldn't it be best to make sure that there is no misunderstanding by spelling out the words?

ALLEN M. CLAGUE, M.D.
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IN REPLY: I appreciate Dr. Clague's suggestions, and agree that clarity trumps conciseness when it comes to abbreviations. At *AFP*, our style is to always spell out the term on first mention, then use abbreviations when: (1) the abbreviation is in general use (for example, COPD for chronic obstructive pulmonary disease), or if it is used more frequently than the words it stands for (for example, HIV for human immunodeficiency virus, AIDS for acquired immunodeficiency syndrome, and ACTH for adrenocorticotropin hormone); or (2) when the term is used so repeatedly in the article that it would become cumbersome to spell it out at each instance (for example, CHF for congestive heart failure). In other instances, I agree with Dr. Clague that it's best to err on the side of spelling things out (for example, we have readers for whom English is not their first language). We will be more vigilant at applying these rules, and thank Dr. Clague for keeping us on our toes.

JAY SIWEK, M.D.
Medical Editor
American Family Physician

Case Report:

Urticaria Following Intentional Ingestion of Cicadas

TO THE EDITOR: I would like to report a case of urticaria following cicada ingestion, related to the recent Brood X cicada invasion.

At the urgent care center in Bloomington, Indiana, where I work, we saw a 45-year-old man who had consumed approximately 30 cicadas and then subsequently developed an erythematous, pruritic rash from his head to mid-calf 30 to 45 minutes after the ingestion. On initial presentation, he complained of an "itching" in his throat but denied any shortness of breath.

His medical history revealed no allergies to medications, but he did report an allergy to shellfish, which had previously caused symptoms similar to the ones he was experiencing. The medications he was taking included fluticasone nasal spray, inhaled fluticasone/salmeterol, zafirlukast, and tamsulosin. He had taken his scheduled medicines that day, as well as two 25-mg tablets of diphenhydramine, orally.

A physical examination revealed: respiratory rate 16 breaths per minute, pulse rate 96 beats per minute, temperature 98.0°F (36.7°C), blood pressure 124/68 mm Hg, and arterial oxygen saturation (SaO₂) 98 percent on room air. His heart rhythm was regular and lung fields were clear. We administered desloratadine 5 mg orally, methylprednisolone 80 mg intramuscularly, and 1:1,000 epinephrine 0.3 mL subcutaneously. The patient was monitored with continuous electrocardiography over the next several hours. He began to feel better, and was discharged home in stable condition. The rash had almost completely resolved.

Further history taking revealed that the patient had downloaded a recipe from the Internet and had prepared the cicadas by sautéing them in butter and garlic. Physicians should caution patients who have experienced allergic reactions to shellfish to avoid ingesting cicadas.

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Antibiotic Use for Streptococcal Pharyngitis Groups C and G

TO THE EDITOR: The article¹ by Vincent and colleagues in *American Family Physician* reviews a topic that is highly relevant to my everyday practice in primary care: pharyngitis. Thank you for articles on such topics. I would like to ask the authors if they have any information on the need or validity of offering antibiotic treatment to patients whose throat cultures reveal groups of streptococci other than A? My laboratory routinely evaluates for groups C and G, and there is some literature²⁻⁵ that suggests that treating these groups of patients may be clinically beneficial. However, I am loath to extend the use of antibiotics further in an era of significant rates of microbial resistance and physician tendency to offer treatments without good evidence of efficacy.

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patient with pyomyositis and reactive arthritis. J Clin Microbiol 2003;41:613-8.

IN REPLY: I would like to thank Dr. Mosby for a most intriguing question. Groups C and G beta-hemolytic streptococci certainly have caused well-documented epidemics of acute pharyngitis. These outbreaks often have been associated with contaminated foods (group C with milk-borne outbreaks and group G with infected egg salad and chicken salad). Groups C and G streptococci also are frequently isolated from asymptomatic persons. Groups C and G streptococci express the virulence factor, M protein.¹ It is difficult to differentiate between colonization and infection. The benefit of antimicrobial therapy has not been established. One author advises that patients with streptococci C and G be treated solely for symptomatic relief.² Others state that there is no proven benefit in treating any pharyngitides other than group A beta-hemolytic strep, *Corynebacterium diphtheriae*, and *Neisseria gonorrhoeae*.^{3,4} It would appear that we do not understand the pathogenic burden of these organisms, although it is known that the more virulent strains express a C5a peptidase enzyme similar to group A beta-hemolytic strep.⁵ My conclusion is that local strain virulence results in the different clinical pathogenic presentations of the organisms under question. The answer: we don't know if groups C and G streptococci deserve antibiotic therapy, and, of course, we never routinely know if they express C5a peptidase.

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