JAOA LETTERS

JAOA—The Journal of the American Osteopathic Association encourages osteopathic physicians, faculty members and students at colleges of osteopathic medicine, and others within the health care 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.

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The *JAOA* prefers that readers e-mail letters 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 address, day and evening telephone numbers, fax numbers, and e-mail address. 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.

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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.

Update on Advisory Committee on Immunization Practices (ACIP) Vaccine Recommendations, June 2012

To the Editor:

At its June 2012 meeting, the Advisory Committee on Immunization Practices (ACIP) approved 2 recommendations: (1) a dose of PCV13 (pneumococcal conjugate vaccine-13 serotypes; Prevnar13, Pfizer Inc, New York, New York), in combination with PPSV23 (pneumococcal polysaccharide vaccine-23 serotypes; Pneumovax, Merck & Co Inc, Whitehouse Station, New Jersey) for individuals aged 19 years or older who are immunocompromised[1] and (2) the 2012-2013 influenza recommendations for children aged 6 months to 8 years.[2] What do these recommendations mean for health care providers?

Recommendation 1 (PCV13)

Patients aged 19 years or older who have functional or anatomic asplenia, immunocompromising conditions, congenital or acquired immunodeficiency, human immunodeficiency virus infection, chronic renal failure or nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, diseases requiring treatment with immunosuppressive drugs such as long-term corticosteroids or radiotherapy, solid organ transplantation, multiple myeloma, cerebrospinal fluid leaks, or cochlear implants are candidates for both PPSV23 and PCV13. Although the US Food and Drug Administration approved PCV13 for children aged 6 weeks through 5 years in 2010[3] and for adults aged 50 years or older in 2011,[4] the ACIP—after review of the research—believed the evidence supported the use of PCV13 for individuals listed above aged 19 years or older.

There are 2 categories of patients: (1) patients who have not received PPSV23 and (2) patients who have received PPSV23. For those who have not previously received PPSV23, PCV13 should be given first, at least 8 weeks before PPSV23 is administered. Individuals who have previously received PPSV23 should be given PCV13 one year after last dose of PPSV23. For persons with functional or anatomic asplenia and for persons with immunocompromising conditions, a second dose of PPSV23 is recommended 1 or more years after PCV13 and 5 or more years after the first dose of PPSV23.

Recommendation 2 (young children and the 2012-2013 influenza vaccine)

The 2012-2013 influenza vaccine will contain the 2009 pandemic H1N1 strain, but the H3N2 and B strains will be replaced. The H3N2 component is changing from A/Perth/16/2009 to A/Victoria/361/2011, and the B component is changing from the Victoria-lineage B/Brisbane/60/2008 to the Yamagata-lineage B/Wisconsin/1/2010. Because 2 doses of influenza vaccine are required to adequately stimulate a young child's immune system, the ACIP approved the following algorithm for children aged 6 months to 8 years:

Ask the following: "Has the child ever received the influenza vaccine?"

- If yes, ask "Did the child receive 2 or more doses of seasonal vaccine since July 2010?"

- ☐ If yes, administer 1 dose.
- ☐ If no or if answer is unknown, administer 2 doses.

- If no or if answer is unknown, administer 2 doses.
- When administering 2 doses, the doses should be given at least 4 weeks apart.

Trivalent influenza vaccine injectable is a killed virus and has been approved starting at age 6 months. Live attenuated influenza virus in nasal spray formula has been approved starting at age 2 years. Osteopathic physicians should consider these new ACIP recommendations as the influenza season arrives.

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Financial Disclosure: Dr Grogg is a primary investigator for vaccine research and has received grants from GlaxoSmithKline plc; Merck & Co, Inc; MedImmune LLC; Novartis Pharmaceuticals; Pfizer Inc; and sanofi-aventis US LLC. He serves on the speakers' bureaus for MedImmune LLC; Merck & Co, Inc, Novartis Pharmaceuticals; and sanofi-aventis US LLC. He is also a consultant for Merck & Co, Inc (for the human papillomavirus), and Novartis Pharmaceuticals (for meningitis).

Need to Oppose Proposed ACGME Common Program Requirements

To the Editor:

Over the past several months, feelings of uneasiness have sprung up among many of us in osteopathic residency programs. On November 11, 2011, we were informed that the Accreditation Council for Graduate Medical Education (ACGME) had proposed 2 new policies that would limit future graduates of osteopathic medical schools from entering ACGME-accredited residency programs.[1] The 2 new proposals of the ACGME Common Program Requirements were as follows[2]:

> III.A.2. Prerequisite clinical education for entry into ACGME-accredited residency programs must be accomplished in ACGME-accredited residency programs or Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited residency programs located in Canada.
>
> III.A.3. Prerequisite clinical education for entry into ACGME-accredited fellowship programs must meet the following qualifications: (a) for fellowship programs that require completion of a residency program, the completion of an ACGME-accredited residency program or an RCPSC-accredited residency program located in Canada; (b) for fellowship programs that require completion of some clinical education, clinical education that is accomplished in ACGME-accredited residency programs or RCPSC-accredited residency programs located in Canada.

The American Osteopathic Association (AOA) responded swiftly to this announcement by opposing the new proposals.[1] The AOA leadership met with ACGME officials at AOA headquarters in March 2012 to advocate for the withdrawal or amendment of the ACGME proposals.[1] After the meeting, residents were informed that the ACGME Board of Directors would review previous committee recommendations in June and provide a definitive decision regarding the proposals.

In June, the American Medical Association's (AMA) House of Delegates approved a resolution related to the Common Program Requirements.[3] The resolution called on the AMA to partner with stakeholder organizations, including the ACGME and the AOA, to revise residency and fellowship accreditation standards to recognize the alignment of the educational experiences of allopathic and osteopathic residents. The AOA announced that this resolution was "a positive action in support of our efforts to resolve the ACGME crisis and preserve access to ACGME programs for DO graduates."[3] At the time of the writing of the present letter, AMA committees were still discussing this matter, and a final decision had not yet been made.

In my opinion, the proposed ACGME Common Program Requirements[2] are a huge blow to the osteopathic medical profession. Not only are thousands of osteopathic medical students and residents impacted by the proposals, but so are entire osteopathic residency programs. Osteopathic medical students wanting to do an ACGME-accredited fellowship and an AOA-approved residency will be forced to reconsider the osteopathic residency. Osteopathic residency programs will no longer be able to attract top candidates.

It is hard to wrap my head around these ACGME proposals.[2] The osteopathic and allopathic medical professions have built a strong partnership during the past 20 to 30 years. The ACGME might oppose the AOA policy that graduates of allopathic medical schools are not allowed to enter into osteopathic residencies or fellowships. I agree with the ACGME on this point. I believe that allopathic

medical school graduates should be allowed to enter into osteopathic residencies, as it is only fair. However, I also believe that the ACGME proposals underscore the fact that there are far fewer osteopathic fellowships than allopathic fellowships, and the few that are in place have not existed long enough to establish the reputation or build the research environment that is required to attract top talent. It is not reasonable for the ACGME to close the door on the opportunities of students and residents of a smaller, less established, more fragile graduate medical education system.

I urge readers of *JAOA—The Journal of the American Osteopathic Association* to contact the ACGME to have your voice heard. Even if the ACGME proposals[2] do not affect you, it is important that we unite and hold a firm stance on this issue.

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Response

We agree with Dr Zeichner and urge individuals to contact the Accreditation Council for Graduate Medical Education (ACGME). We would also like to provide clarifying comments to Dr Zeichner's points. The American Osteopathic Association (AOA) continues to work aggressively to address the proposed ACGME rules. A Joint AOA-ACGME Task Force is searching for ways to resolve this situation. The Task Force has met 3 times in the past 4 months, and a fourth meeting is scheduled.

The issue of allowing MDs into DO training programs is complex, and it has been studied by a special AOA task force. Their report has been discussed and debated by both the AOA Board of Trustees and the AOA House of Delegates. Before admitting allopathic graduates into osteopathic programs, several important hurdles must be addressed, including prerequisite training, certification, and AOA membership. First, AOA residencies incorporate an additional core competency, "Osteopathic philosophy, principles and manipulative treatment," beyond the other 6 competencies shared by the AOA and the ACGME. The required elements of this competency are fully integrated within the teaching and evaluation of the remaining competencies in each specialty's respective training standards. Accordingly, allopathic graduates would need some form of prerequisite training to enter an osteopathic training program. There is currently no approved curriculum available to teach allopathic graduates what osteopathic students learn about osteopathic principles and practices (including osteopathic manipulative treatment) in their 4 years of osteopathic medical school.

Second, there is no board certification process for the allopathic graduates who would complete an osteopathic training program through either the AOA or the American Board of Medical Specialties (ABMS). We believe it would be unethical to train someone who would not be eligible for board certification. The ABMS does not recognize osteopathic postdoctoral training and, therefore, would not certify allopathic physicians (ie, MDs) who complete osteopathic residencies. (As a slight digression, the ABMS does not certify osteopathic physicians [ie, DOs] who complete allopathic fellowships after completing osteopathic residencies. The AOA has created certifications for those DOs who have followed this training path.)

Third, osteopathic board certification requires regular membership in the AOA to monitor the ethics, licensure status, and CME (and soon osteopathic continuous certification) of certified members. Allopathic physicians are not eligible for regular membership in the AOA, so this would need to be addressed as well.

It should be noted that many residency programs currently are accredited by both AOA and ACGME. Allopathic graduates of these programs are eligible for board certification by the ABMS. Although these dually approved programs have traditionally been created in existing primary care ACGME residencies, there is no prohibition for AOA-accredited residency programs to seek additional accreditation through the ACGME. This step would allow traditionally osteopathic programs to accept allopathic graduates who would be eligible for board certification upon successful completion.

At its July 2012 meeting, the AOA Board of Trustees and House of Delegates heard an update on the AOA-ACGME discussions. We also reported on this issue to the AOA Bureau of Osteopathic Specialty Societies and the Council of Interns and Residents during their July meetings. The leadership of the AOA continues to hold a preference for this issue to be resolved in an amicable, collaborative way. We believe that writing letters to encourage the ACGME to reconsider their proposed rule is the right approach at this time.

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Paradoxical Hyponatremia and Polyurodipsia in a Patient With Lithium-Induced Nephrogenic Diabetes Insipidus

To the Editor:

Diabetes insipidus is a condition marked by polyuria that is caused by the inability of the kidneys to reabsorb free water. There are various causes of diabetes insipidus, which can be further classified into the central and nephrogenic subgroups. Central diabetes insipidus is characterized by injury to the neurohypophysial system and is often the result of hypoxic encephalopathy, iatrogenic injury to the pituitary gland during surgical procedures, and autoimmune attack to vasopressin-producing cells in the hypothalamus. Nephrogenic diabetes insipidus is characterized by the inability of the kidneys to respond to adequate levels of vasopressin, often the result of chronic lithium use, which injures the collecting ducts of the kidneys.[1] However, inheritable forms of nephrogenic diabetes insipidus exist as well.[2]

A 43-year-old man with a history of schizoaffective disorder was hospitalized and treated numerous times during the course of several months for hyponatremia; sodium levels as low as 117 mmol/L were recorded. The hyponatremia was believed to be a result of psychogenic polydipsia at the time of treatment.

The patient presented to a small community hospital in North Carolina with watery vomiting and severe headache of 2 days duration. Review of symptoms revealed polydipsia and polyuria. The patient admitted to drinking excessive amounts of water, attributing it to his constant and overwhelming thirst and dry mouth. In his group home, he had been observed drinking water from the toilet and sink. The patient stated that he received lithium therapy for his schizoaffective disorder from 1986 to 1997. The therapy was reinitiated in 2011 and continued until the time of presentation. The patient reported that the constant thirst was present when he was receiving lithium; he denied that the thirst was present prior to 1986 and during the period when he was not receiving lithium. The patient's symptoms of headache and vomiting corresponded to his hyponatremia and resolved with treatment of his hyponatremia during each hospitalization.

The behavioral health department was consulted, and the psychiatrist indicated that the previous diagnosis of psychogenic polydipsia, an extremely rare condition most commonly found in patients with brain injury, mental retardation, or severe schizophrenia, was unlikely given the patient's history and presentation. In addition, the patient's lack of prior history of severe episodes of polydipsia suggested that the dry mouth and vasopressin resistance were a result of medication changes. Lithium (300 mg), paliperidone (3 mg), and haloperidol (5 mg) were discontinued and replaced with valproic acid (500 mg) and risperidone (1 mg) on discharge.

Hyponatremia is not typically seen in patients with diabetes insipidus. Hypernatremia is expected but can typically be corrected to normal levels with increased water intake. Osmoreceptor function, which is intimately connected with controlling the thirst mechanism, is typically not compromised in patients with diabetes insipidus, so thirst should resolve as hypernatremia is resolved. For patients with diabetes insipidus who have hyponatremia, the syndrome of inappropriate secretion of antidiuretic hormone (SIADH) and cerebral salt-wasting syndrome should be considered. With SIADH, the unregulated release and subsequent activity of vasopressin leads to hyponatremia caused by excess fluid retention. Urine output can decrease markedly, with urine sodium concentrations being notably high, usually above 40 mEq/L. Neither low urine output nor high urine sodium concentrations were observed in our patient. Measurements of plasma vasopressin, plasma osmolality, and urine vasopressin are also helpful in the general differential diagnosis of polyuria and polydipsia.[3] Cerebral salt-wasting syndrome is a poorly understood diagnosis.[4] Theoretically, it has been proposed[4] that aberrations in the sympathetic nervous system, which is responsible for renin release, and a circulating factor released during brain injury may inhibit renin release. Similar to SIADH, elevated urine sodium levels are expected with cerebral salt-wasting syndrome.

The present case illustrates an extremely rare consequence of lithium-induced nephrogenic diabetes insipidus, in which an overlying psychogenic polydipsia led to paradoxical hyponatremia. Future studies should include the pathophysiology of diabetes insipidus, as well as possible causes for alterations of the osmolar set point of the hypothalamic osmoreceptors, which may inadvertently result in increased thirst.

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