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MADAROSIS FROM COCAINE USE

To the Editor: A 17-year-old male patient with a known case of acquired immunodeficiency syndrome (AIDS)-related complex (persistent lymphadenopathy, night sweats, mild weight loss, and serum positivity to human T-cell lymphotropic virus Type III) was noted on examination to have a bilateral loss of eyebrow and eyelash hair. There was no other hair loss, no facial rash, and no evidence of subcutaneous edema or infiltrate. The ocular examination was also normal. The patient reported that he had not manipulated his eyebrows or applied any medications or creams to his face.

Careful questioning revealed that the patient had recently had increased use of free-base cocaine in the form of "crack." This pure crystallized cocaine is now readily available in many parts of the United States. It is generally placed in a glass pipe, then ignited and inhaled. It appears that the hot cocaine vapors rising rapidly from the pipe can singe the eyebrows and eyelashes, with resultant loss.

When the patient abstained from cocaine, as documented by negative urine toxicologic tests, the lost hair began to regrow.

We suggest that madarosis should join chronic rhinitis or rhinorrhea and nasal septal ulceration or perforation as symptoms that should make alert clinicians think of illicit cocaine use.

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BOWL-GAME PULMONARY EMBOLISM

To the Editor: Pulmonary embolism is rarely diagnosed in the absence of some recognized coexisting illness or predisposing factor.* A recent patient of ours had a pulmonary embolus without any initially apparent predisposing conditions. He seems, however, to have had a previously unrecognized thromboembolic risk factor, which may be increasingly prevalent in the American population.

The patient was a 40-year-old bartender who was well until the night of January 2, 1986, when he suddenly experienced sharp, pleuritic, left-sided chest pain, without other symptoms, while standing at work. He gave no history of extended travel or recent surgery, and there was no personal or family history of clotting abnormalities. On physical examination he was afebrile, with a pulse rate of 88 and a blood pressure of 130/70. The extremities were without edema, tenderness, or cord. The lung examination revealed dullness and decreased breath sounds at the left base. A chest film was remarkable only for a left pleural effusion. After an "indeterminate" ventilation–perfusion scan, a pulmonary arteriogram demonstrated an embolus in a segmental artery of the left lower lobe.

The patient was questioned further. He awoke at noon on New Year's Day, lay down on his sofa, watched three consecutive football games on television, and then went back to bed. For a period of more than 40 hours, he did not leave his home, and he stirred only occasionally for refreshments. The temporal relation of this extended inactivity to his embolic event strongly suggests that deep venous thrombosis developed while he was watching the "Bowl" games, or soon after. Hence, "Bowl-Game pulmonary embolism" needs to be considered in the differential diagnosis of chest pain during appropriate high-risk seasons.

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*Bell WR, Simon TL, DeMets DL. The clinical features of submassive and massive pulmonary emboli. Am J Med 1977; 62:355-60.

RESIDENCIES FOR FOREIGN MEDICAL GRADUATES

To the Editor: In the Health Policy Report entitled "Reducing Residency Opportunities for Graduates of Foreign Medical Schools" (Sept. 26 issue),* John K. Iglehart refers to data on the results of the initial administration of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) in July 1984. Specifically, the report cites correctly a pass rate of 3.8 percent for the American citizens who took the full two-day examination, and compares this with a much higher pass rate for alien physicians who took the same examination. This would lead one to conclude that U.S. citizens who are students at or graduates of foreign medical schools perform considerably less well on this examination than their foreign-citizen counterparts.

Such a conclusion, however, would be specious, for it would not take into account the need to control for a powerful but extraneous variable — namely, the disproportionate number of repeaters in the two groups. Repeat examinees would include those who failed one or more of the previous, now discontinued examinations of the Education Commission for Foreign Medical Graduates or the Visa Qualifying Examinations or both. Excluding repeaters, the data on pass rates for first-time examinees who sat for the two-day FMGEMS show little difference between graduates of foreign medical schools who are U.S citizens and those who are aliens (Table 1).

Table 1. Performance of U.S. Citizens and Aliens Who Took the Two-Day FMGEMS for the First Time in July 1984.

Examinees	Total No.	No. (%) Who Passed		
		Day 1, Basic Science	Day 2, Clinical Science	Both Days
U.S. citizens	164	40 (24)	92 (56)	39 (24)
Aliens	2267	685 (30)	1313 (58)	676 (30)

When Mr. Iglehart was preparing his excellent report he did not have access to these data — a fact that we regret. The full data on this and the subsequent FMGEMS of January and July 1985 will appear in *U.S. Medical Licensure Statistics and Licensure Requirements*, which is published by the American Medical Association, and in the annual reports of the Educational Commission for Foreign Medical Graduates and the National Board of Medical Examiners.

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*Iglehart JK. Reducing residency opportunities for graduates of foreign medical schools. N Engl J Med 1985; 313:831-6.

To the Editor: Iglehart's report maintains his record of identifying and illuminating national health policy issues of importance and widespread interest. He correctly emphasizes that the congressional concern regarding the graduate medical education of foreign medical school graduates is focused on reduction of the federal cost provided through Medicare. This is understandable inasmuch as the total direct costs for residents' salaries in the United States can be estimated to be $2 billion (79,655 residents × $25,000 average annual salary), which is increased two to three times by the indirect costs allowed in the reimbursement formula for patient care in teaching hospitals, and the total direct cost for residents from foreign medical schools is over $336 million, of which 40 percent comes from Medicare funds. Cost was not, however, the central or even emphasized concern of the New York State Commission on Graduate Medical Education, as suggested by Mr. Iglehart.

The New York State Commissioner of Health, Dr. David Axelrod, in his charge to the commission, mentioned the quality of the preparation of applicants for residency, overrepresentation of subspecialty training, the medical needs of specific population groups,