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.

Postdoctoral Core Competencies in the Predoctoral Curriculum

To the Editor:

The Kirksville (Mo) College of Osteopathic Medicine of A.T. Still University of Health Sciences (KCOM/ATSU) in Kirksville, Mo, is undergoing accreditation for the North Central Association of Colleges and Schools and the American Osteopathic Association (AOA). A self-study report comprises a significant portion of the documentation that must be provided for review. With regard to the curricular elements of this report, we elected (and received permission) to adapt the AOA core competency requirements for postdoctoral training into a suitable grid for evaluating predoctoral medical education.

Because the AOA competency standards are inclusive, it was necessary to change only the performance expectation and the scope of function to make the standard applicable for medical students. However, we also needed to develop a method to determine the extent to which our undergraduate medical education curriculum matched the core competencies by linking the learning activities our students were engaged in to the specific core competencies. Therefore, we created a database of our entire 4-year curriculum based on the core competencies and sub-elements. The database included the course name and its department of origin, learning objectives, quarter(s) in the academic calendar in which the objective is taught, as well as methods of teaching and assessment. A collection tool was sent to all course directors and curriculum committee members, and informational forums were held with course directors and instructors to explain the purpose of the project and to ensure consistency of data collection. Course directors placed their educational goals and/or learning objectives into the database by course. The faculty response to the effort was good. Nearly all course directors had clearly defined learning objectives, which made data collection relatively easy.

This database has allowed KCOM to better analyze its medical education curriculum and to assess the teaching and testing of the core competencies during the 4 years of its program. We have found that some important skills, such as communication with patients, develop over time and are assessed at different levels along the continuum of the curriculum. We have also found that in some courses, learning activities relating to the development of interpersonal and communication skills and professionalism were not formally recognized in the course objectives. These learning activities occurred in laboratory and other small group activities.

Based on the benefits we found by comparing our curricular content and course goals with the (adapted) AOA core competency standards, we are extending our evaluation to include our “exit objectives.” These objectives, which...
have been used at KCOM/ATSU for about a decade, are the learning objectives for the entire medical school curriculum. We expect this review to be completed by late fall 2006.

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References

Interventions Need to Be Consistent With Osteopathic Philosophy

To the Editor:
As a researcher, chiropractic clinician, and beginning first-year osteopathic medical student, I found several shortcomings in the review of pediatric migraine by Andrew D. Hershey, MD, PhD, and Paul K. Winner, DO, appearing in the supplement to the April 2005 issue of JAOA—The Journal of the American Osteopathic Association (2005;105 suppl 2):S2–S8). Specifically, the authors neglected to accurately detail nonpharmacologic treatment modalities such as dietary and nutritional interventions. Further, they do not mention manipulative treatment.

In contrast to the description of the osteopathic medical profession by the American Osteopathic Association,1 namely, “doctors of osteopathic medicine, or D.O.s, apply the philosophy of treating the whole person to the prevention, diagnosis and treatment of illness, disease and injury,” Drs Hershey and Winner essentially reviewed only pharmacologic treatment. They dedicated 2597 words (97.7%) to pharmacologic treatment but incompletely reviewed nonpharmacologic treatment modalities in only 62 words (2.3%).

Drs Hershey and Winner did not mention clinical trials showing benefit of magnesium supplementation in pediatric patients with migraine.2 Modes of therapy under the genre of “biofeedback” appear to be safe and effective for pediatric migraine.3,5 Perhaps more important, the authors neglected to objectively review data on diets that eliminate food allergens, which have been proved effective as a migraine preventive in children3,6 and adults.8 Furthermore, while it is true that the adult studies documenting the antimigraine benefits of spinal manipulation,9 coenzyme Q10 (CoQ10),10 riboflavin,11 feverfew,12 Petasites hybridus,13 vitamin D,14 cobalamin,15 5-hydroxytryptophan,16 and combination fatty acid therapy17 need to be replicated in children, Drs Hershey and Winner either ignored or too quickly dismissed these low-cost, low-risk interventions, which have shown clinical efficacy when used singly and which may also be used safely in combination.18,19

Although the US Food and Drug Administration generally does not “approve” the use of nutritional supplements for the treatment of disease in the same way that it does pharmaceutical medications, lack of such approval does not imply lack of efficacy or safety. To my immediate knowledge, only soy, dietary fiber/fruit/vegetables, stanols/sterols, calcium, and folic acid have received such “approval” for health claims (see http://www.cfsan.fda.gov/%7Edms/fig-6c.html). Nonetheless, as noted in the previous paragraph, there exist studies proving the effectiveness of riboflavin, CoQ10, magnesium, biofeedback, elimination of food allergens, spinal manipulation, feverfew, Petasites hybridus, 5-hydroxytryptophan, and fatty acids against migraine. Furthermore, for example, studies have shown that omega-3 fatty acids reduce the risk of cardiovascular death more effectively than statin drugs, which are “approved,” yet I am not aware that fatty acids have been officially “approved” despite this obvious show of safety and effectiveness.20

It is hoped that future reviews in this journal can include a more balanced survey of the literature, inclusive of nonpharmacologic and “holistic” interventions that are consistent with osteopathic philosophy.

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Editor’s Note
Dr Vasquez disclosed that he has been a researcher for Biotics Research Corporation in Rosenberg, Tex. Biotics Research Corporation does not sell products, testing, treatments, or training associated with biofeedback, food allergy, spinal manipulation, feverfew, Petasites hybridus, or high-dose riboflavin. Biotics Research Corporation does produce nutritional supplements containing magnesium, coenzyme Q10, vitamin D, cobalamin, 5-hydroxytryptophan, and fatty acids.

References
Corrections

The correct text for this clinical studies abstract should have appeared as shown below:

C18

Addition of Laminin and Fibronectin to SIS Used as Conduits in Peripheral Nerve Repair
Jacqueline C. Oxenberg, MS III, Ryan Smith, DO, MBA,1 Douglas Troutman, MS III,1 Richard Kriebel, PhD,2 Charlotte Greene, PhD;3 Philadelphia College of Osteopathic Medicine, Philadelphia, PA 19131;1 Tripler Army Medical Center, Honolulu, HI

This is a pilot study using laminin and fibronectin as an additive to small intestine submucosa (SIS) grafts used to repair transected sciatic nerve in a rat model. Previous studies in our lab have shown sciatic nerve regeneration to be successful using SIS grafts without growth factors. SIS is a biological material that may be used to correct problems of larger peripheral nerve gap injuries and improve regrowth by acting as a natural guide between the proximal and distal segments of the nerves, providing the proper growth environment with minimal antigenicity, thus decreasing chances of rejection. Other studies have shown the addition of fibronectin to various types of grafts further enhanced nerve regeneration by promoting Schwann cell growth. The goal of this study is to determine whether adding laminin and/or fibronectin to SIS grafts improves sciatic nerve regeneration. The experimental group had a 10 mm segment of the right sciatic nerve resected followed by placement and suturing of and SIS graft plus laminin and/or fibronectin laced in the gap as a conduit for nerve regeneration. The control group had the right sciatic nerve resected and reattached directly. Schwann cell growth and nerve regeneration were assessed using anti-s100 antibody, and fast cresyl violet stain to assess Schwann cell migration and neuron regeneration respectively. Preliminary results indicated that:

1. Schwann cell migration and accompanying neuron infiltration occurred up to approximately 2.5 cm over the 6-month healing time in experimental animals.

2. Healing in control animals was observed to be inhibited by the formation of collagen scar tissue.

3. Gait analyses show increased sciatic function in experimental groups of laminin and/or fibronectin compared to control groups.

These results exceed previously reported rates of peripheral nerve regeneration using non-SIS graft materials and show addition of laminin and/or fibronectin improve both sciatic nerve regeneration and sciatic function in gait analyses.

The August 2006 issue of the JAOA has been corrected online to reflect this change. In addition, the abstract, as reprinted in the final program for the 50th Annual American Osteopathic Association Research Conference, has been corrected in advance of publication:


This poster is entered in the Student Prize Competition, a judged event that takes place during the Foster Session at the Research Conference.