

## THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

DEPARTMENT OF RADIOLOGY  
DIVISION OF NUCLEAR MEDICINE  
DAVID V. BECKER, M.D., DIRECTOR

April 13, 1994

The Hon. Ivan Selin  
Chairman  
United States Nuclear Regulatory Commission  
Washington D.C. 20555

Dear Chairman Selin,

In a recent white paper, the Nuclear Management and Resources Council (NUMARC) restated their opposition to the stockpiling and distribution of potassium iodide. In support of their opinion, they quoted a paper I wrote (JAMA, 1987 258:649) which reviewed public health strategies in the management of reactor accidents. Some of the problems in the logistics of KI distribution were discussed and quoted by NUMARC but my paper's conclusion that before a sound public policy could to be established, additional scientific information was required, was ignored.

That paper was written at the invitation of the American Medical Association for a 1986 international conference on non-military radiation emergencies and was subsequently published with my affiliation to New York Hospital-Cornell Medical Center listed. In NUMARC's white paper, selected comments about potassium iodide distribution were extracted from the paper and attributed to me as "Chairman of the American Thyroid Association", an incorrect affiliation.

Unfortunately, NUMARC ignored two major position papers of the American Thyroid Association (ATA) on potassium iodide stockpiling, and distribution. One policy statement "The Use of Iodine as a Thyroid Blocking Agent in the Event of a Reactor Accident" (JAMA 252:659, 1984) was the report of the Environmental Hazards Committee of the Association and received the unanimous endorsement of the entire organization. That statement, representing the official policy of the Association recommended advance planning for possible distribution of KI (although not the distribution itself).

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The most recent statement of the Association appeared as a letter to the editor of the JAMA entitled "Potassium Iodide Stockpile for Nuclear Accidents" (JAMA 263:1632, 1990) and reexamined the issue of stockpiling KI and concluded that "...The ATA believes that the option of potassium iodide distribution should be available for consideration...To this end, the ATA believes that it would be prudent to have available at central locations a suitable stockpile of potassium iodide for possible distribution should its use be contemplated."

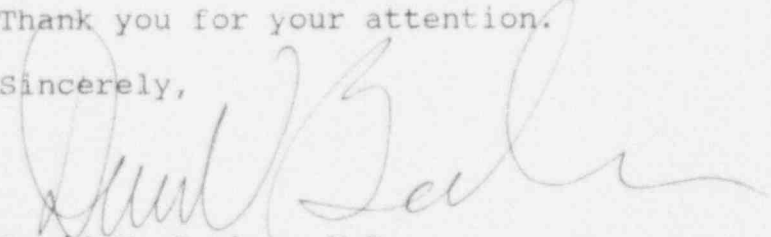
Subsequently, at the behest of the ATA, the CDC and NRC held a conference on the subject. At that meeting, I expressed the opinion, as did other representatives of the American Thyroid Association, of the importance of stockpiling KI. The usefulness of advance individual distribution was noted to be of uncertain effectiveness in the face of the limited existing information unless appropriate studies were made of logistical issues in distribution.

I learned of NUMARC's white paper incidentally while at an IAEA meeting in Vienna, and on my return to New York called to NUMARC's attention their error in attributing my personal opinion (incorrectly quoted) to the American Thyroid Association. This was a matter of some distress since they implied an opposite opinion to me and to the ATA than was held, ignoring the published and existing opinions of the ATA on this subject.

A recent letter that NUMARC sent to the Commissioners (April 1, 1994) corrects the issue of my position and title but unfortunately did not indicate the substantive and repeated ATA decision favoring potassium iodide stockpiling.

Thank you for your attention.

Sincerely,



David V. Becker, M.D.  
Professor of Radiology and Medicine  
Director, Division of Nuclear Medicine

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Enclosure

cc: Dr. P.R. Larson, President ATA

tens of millions of our citizens who have no health insurance, and many need care now. This approach can help.

And, yes, in contrast to some, this editor recognizes an ancient ethic that espouses that we all are indeed "our brother's keeper."

George D. Lundberg, MD

1. Lundberg GD, Bodine L. Fifty hours for the poor. *JAMA*. 1987;258:3157.
2. Lundberg GD, Bodine L. Fifty hours for the poor. *JAMA*. 1989;260:3178.
3. Lundberg GD, Bodine L. Fifty hours for the poor. *JAMA*. 1989;262:3045.
4. Bodine L. It pays to stick your neck out: fifty hours for the poor. *JAMA*. 1989;260:3127.
5. Davis JE. Let's work together! A call to America's physicians and the public we serve. *JAMA*. 1988;260:834-836.
6. Gunby F. First public service award goes to Kentucky. *JAMA*. 1988;260:3196.

*In Reply.*—Dr Evans will be interested to know that 100 000 lawyers participate each year in some 500 organized pro bono programs for the poor in this country. This does not include private, non-reported pro bono work for the local church, art center, or service club. Since August 1988—7 months after the editorial was first published in the *ABA Journal* and *JAMA*—it has been the official policy of the American Bar Association that lawyers should devote at least 50 hours of their time to the poor each year.

Dr Haynes misses the point. I believe that the moral price for holding a license to practice a profession of specialized knowledge is devotion of some of one's skills at no charge to the needy. The country cannot afford otherwise.

Dr Tauber is wrong. The duty to devote time to the poor arises not from the wealth of attorneys and physicians, but from their privilege to practice their skilled arts for pay. Government cannot do it all, as Medicare and the Legal Service Corporation demonstrate. The country also needs the pro bono efforts of its professionals.

Laurence Bodine, Esq  
*Lawyer's Alert*  
Wheaton, Ill

### History and Examination Should Precede Tests

*To the Editor.*—Dr Kolder,<sup>1</sup> in his discussion of a patient who suffered loss of vision following cataract surgery, correctly indicates the unlikelihood of the proffered diagnosis of multiple evanescent white dot syndrome. He also briefly lists a potpourri of entities that may have resulted in visual loss following a surgical procedure. If Dr Kolder had been less kind, he might have pointed out that a markedly restricted peripheral vision in an eye with permanent loss of central vision is not compatible with the physical findings as given, specifically, a normal optic disc and a "dissipated" swollen retina. He also might

have pointed out that a brain scan, electroretinogram, and fluorescein angiogram would have little likelihood of showing an abnormality that was not suspected on the basis of a careful ophthalmologic examination.

It seems to me that this problem is another illustration of how readily physicians discard the use of a careful history, physical examination, and logic in favor of easy technological procedures and their reported results. Physical examination takes the physician's time, tests do not.

One of the initial allures of ophthalmology for many physicians, and I am sure that this is true in other specialties as well, is the gratification that comes from being able to make a presumptive diagnosis on the basis of a careful history and physical examination. In my ophthalmologic experience, a presumptive diagnosis can be made on this basis 95% of the time and tests are only confirmatory. If the patient in question had normal visual function prior to cataract surgery, then it is not anatomically or physiologically possible for the patient to have a malfunctioning optic nerve or malfunctioning retina without there being evidence of that disorder in the physical examination. Physical examination tests such as pupillary response, color vision, stress test, noncomputerized visual field, and biomicroscopic examination of the retina invariably indicate the site and pathophysiology of any dysfunction, if not the exact clinical entity. A proper physical examination demands the recognition by the examiner of the incompatibility of normal ocular findings in the presence of significant visual pathology. If the questioner desires the explanation for the patient's poor visual acuity, she should be evaluated by someone who is experienced in the use of traditional medical methods.

Michael Rosenberg, MD  
Northwestern University  
Medical Center  
Chicago, Ill

1. Kolder H. Vision loss after cataract surgery. *JAMA*. 1989;262:3058.

### Potassium Iodide Stockpile for Nuclear Accidents

*To the Editor.*—The American Thyroid Association (ATA) has long had an interest in the thyroidal consequences of nuclear reactor accidents because of the large amounts of radioiodine that would be released into the atmosphere. The ATA also has endorsed the use of potassium iodide as an effective radioprotective agent. In light of the Chernobyl disaster, the ATA has reexamined the issue of potassium iodide stockpiling for use in the event of a core melt accident

and has adopted the following statement:

The recent reactor accident at Chernobyl, in which large amounts of radioactive iodine were released into the atmosphere, again raised questions about proposed methods of protecting those at risk of exposure. In a previous statement,<sup>1</sup> the ATA reviewed the scientific information available about the usefulness of potassium iodide as a blocking agent to prevent radioactive iodine from entering the thyroid gland of those exposed to fallout. It also reviewed available data about the possible effects on the thyroid of low-level radiation exposure from radioiodine as well as the potential toxic side effects of distribution of potassium iodide to large, unsupervised populations.

It was concluded at that time that information necessary for the development of a suitable public health strategy required risk/benefit data (ratio of the risk of the hazards of radioiodine exposure to those of stable iodine administration) but that such information was not available then. The ATA is aware of no new information that alters the issues raised at that time.

It was concluded in that report that although the general distribution of potassium iodide was not recommended except in special locations and under special circumstances, advanced planning for possible distribution was advisable, and it urged that a national task force of specialists be convened to review the issues in potassium iodide distribution and to develop alternate national distribution strategies for consideration.

As best as can be determined at this time, no substantial stockpile of potassium iodide is available for public use. Despite the improbability of an emergency that requires its use, the ATA believes that the option of potassium iodide distribution should be available for consideration to those responsible for public health measures. *To this end, the ATA believes that it would be prudent to have available at central locations a suitable stockpile of potassium iodide for possible distribution should its use be contemplated.*

It is hoped that this recommendation will generate renewed discussion of this important question.

American Thyroid Association

David S. Cooper, MD, The Johns Hopkins University School of Medicine, Baltimore, Md; David V. Becker, MD, New York (NY) Hospital-Cornell Medical Center; Bertrand Brill, MD, University of Massachusetts Medical Center, Worcester; John T. Dunn, MD, University of Virginia School of Medicine, Charlottesville; Eduardo Gaitan, MD, University of Mississippi School of Medicine, Jackson; Raymond Lindsay, PhD, University of Alabama School of Medicine, Birmingham; Marvin Mitchell, MD, Tufts University School of Medicine, Boston, Mass; and Lester Van Middlesworth, MD, University of Tennessee School of Medicine, Memphis.

1. Becker DV, Braverman LE, Dunn JT, et al. The use of iodine as a thyroidal blocking agent in the event of a reactor accident: report of the Environmental Hazards Committee of the American Thyroid Association. *JAMA*. 1984;252:668-661.

### Pimping

*To the Editor.*—In the November 10, 1989, Letters column, Dr Kleinman<sup>1</sup> quite correctly calls attention to the fact that the word *pimping* does not exist in any dictionary.