tain their incomes" through coding practices. Perhaps this is the best time to address the question that appears to be on many readers' minds: Is fee code creep the result of physicians trying to give themselves a raise? The letters from Drs. Richardson and Hanley do not quite suggest this, but they do suggest the similar hypothesis that doctors have been using their discretionary powers in coding visits to counter the downward pressures on their incomes. Weighing against this hypothesis, however, is our observation that fee code creep occurred long before the expenditure caps of the 1990s. Indeed, the fees for intermediate and minor assessments rose by 2% to 3% per year between 1981 and 1988,[2] even after adjustments for inflation in the health care sector,[3] yet the ratio of intermediate to minor assessments (I–M ratio) rose by 10% per year during the same period.

I would argue that searching for greed as a motive is unproductive. An

Diagnosis of chest discomfort simplified

In this letter I describe 2 easily performed yet effective diagnostic tests for patients who present with chest pain. The first, which I refer to as the "sternal pressure test," is particularly helpful for women with atypical chest discomfort with or without dyspnea. Such patients frequently report discomfort and dyspnea associated with using the upper body musculature (e.g., making beds or carrying heavy items) or positioning the arms over the head (e.g., putting articles away on high shelves).

The test is conducted as follows. The physician places one hand over the upper third of the sternum, supports the back with the other hand (Fig. 1) and then exerts light pressure over the sternum for approximately 10 seconds. The test may be repeated with the hand placed over the middle third of the sternum. If the patient complains of dyspnea, discomfort, a choking sensation or a sense of suffocation during the test, the result is considered positive.

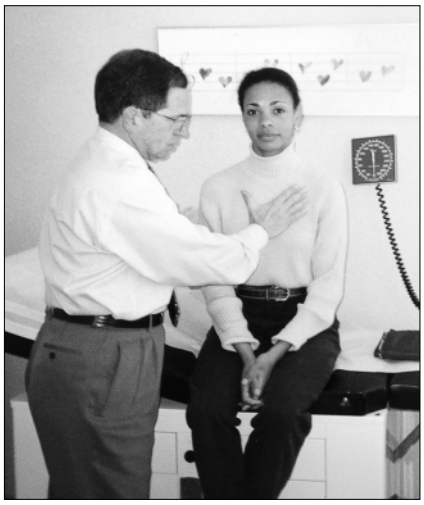

Fig. 1: The sternal pressure test.

Recently I have tried to quantify the results of this test by placing a partially inflated blood pressure cuff between the sternum and the palm of the observer's hand. In patients with a positive result, it is seldom necessary to go beyond 25 to 30 mm Hg pressure to elicit a response.

I believe this test could become an integral part of the physical examination of women (and perhaps some men) with atypical chest pain and dyspnea.

The second test is the "15-second CPS test," which is conducted as follows. The seated patient is instructed to hold the hands together in front of the body at eye level, with the palms up. There should be only a slight flexion of the elbow (Fig. 2). The *Compendium of Pharmaceuticals and Specialties* (CPS) (or any other large book weighing about 2 kg) is then placed in the patient's outstretched hands. The patient is asked to maintain the book at that level for up to 15 seconds and to describe any symptoms that develop.

Patients, particularly women, whose chief presenting symptoms include chest pain or dyspnea are frequently unable to hold the book in position for longer than a few seconds, which is considered a positive result. Even those who can hold the book in the designated position quickly begin to report dyspnea, choking, and back, arm, shoulder and retrosternal pressure as well as a sensation of oppressiveness or suffocation and even palpitations and sweating. A positive result is rare in men.

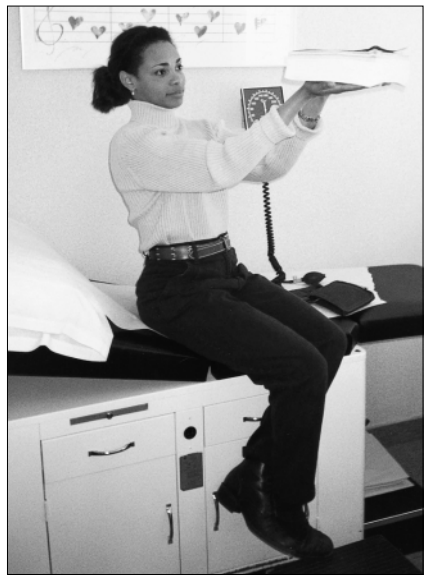

Fig. 2: The 15-second CPS test.

Although a positive result for either of the tests described here does not imply the absence of other sources of discomfort, it certainly raises the possibility of a chest wall cause. I hope that others will carefully evaluate both of these procedures to determine their usefulness.

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