Correspondence

Compression Therapy to Prevent Recurrent Cellulitis of the Leg

TO THE EDITOR: Webb et al. (Aug. 13 issue) presented the results of a randomized, controlled trial of compression therapy in patients with chronic leg edema and recurrent cellulitis. Leg compression therapy plus education was significantly better than education alone (control) with regard to cellulitis prevention in a cohort of patients that was heterogeneous (as indicated by the distribution of characteristics in Table 1 of their article). It is apparent that a substantial proportion of patients had multiple factors contributing to chronic leg edema. Venous stasis due to morbid obesity was a frequent cause of leg edema, and the results of this trial are welcome for this group of patients with a challenging condition.

Chronic venous disease, which was apparently classified as clinical class C3 through C5 according to the clinical, etiologic, anatomical, pathophysiological (CEAP) classification system (with classes ranging from C0 [no signs of venous disease] to C6 [active ulceration]), was also frequent in the trial population. We are curious about the frequency of recurrent cellulitis among patients with chronic venous disease, given that cellulitis is often indistinguishable from dermatitis or hypodermatitis, which are recognized manifestations of CEAP clinical class C4 chronic venous disease.2,3

Stavros K. Kakkos, M.D., Ph.D.
University of Patras Medical School
Patras, Greece
kakkos@upatras.gr

Andrew N. Nicolaides, M.S., Ph.D.(Hon.)
Imperial College London
London, United Kingdom

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THE AUTHORS REPLY: In this pragmatic trial we accepted a diagnosis of cellulitis made by external treating physicians. We agree that misdiagnosis can occur,1 particularly in patients who have clinical manifestations of chronic venous disease.2 The randomized design of our trial supported the equal distribution of participants with chronic venous insufficiency across the two groups: 29% in the compression group and 26% in the control group. Of the 23 participants who had received a diagnosis of cellulitis, 6 (26%) had chronic venous insufficiency — specifically, 3 of 6 participants (50%) in the compression group and 3 of 17 (18%) in the control group.

In practice, several noninfectious conditions can be misdiagnosed as cellulitis. Our trial, within the limitations we acknowledged, showed that the use of compression therapy in patients with a previous diagnosis of cellulitis led to a lower risk of subsequent development of symptoms and signs consistent with cellulitis than education alone.
Elizabeth Webb, M.P.H.
Calvary Public Hospital Bruce
Canberra, ACT, Australia
elizabeth.webb@calvary-act.com.au

Francis J. Bowden, M.D.
Australian National University
Canberra, ACT, Australia

Bernie Bissett, Ph.D.
University of Canberra
Canberra, ACT, Australia

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The “All of Us” Program and Indigenous Peoples

TO THE EDITOR: In his Perspective article (July 30 issue),1 Fox raised compelling issues about medical research and considerations specific to Indigenous communities. He referenced the “All of Us” research program and our imperative to address these issues. We welcome this discussion. Indeed, Fox described challenges we have been navigating in collaboration with tribal leaders and the National Institutes of Health Tribal Advisory Committee.

To address persistent underrepresentation and eliminate health disparities, it is essential to rebuild trust with Indigenous communities. Listening to input from tribal communities strengthens research practices and will ultimately improve health.

Our recently posted preliminary report chronicles 14 months of tribal consultation on inclusion of American Indian and Alaska Native people.2 Guided by a framework for ongoing engagement with tribal nations,3 we seek to root the program in respect for tribal sovereignty, cultural sensitivity, data protection, and inclusive governance.

We are grateful to the tribal communities guiding this work and look forward to continued input from stakeholders, including Fox. Only through meaningful dialogue can All of Us chart a path toward respectful inclusion that benefits all participants.

Stephanie A. Devaney, Ph.D.
National Institutes of Health
Bethesda, MD
stephanie.devaney@nih.gov

Chief Lynn Malerba, D.N.P., M.P.A.
Mohegan Tribe
Uncasville, CT

The author replies: Although there have been considerable advances in biomedical research in recent decades, only marginal progress has been made in including underrepresented minorities in studies that will inform the future of precision medicine.1-3 I appreciate the attention that the All of Us leadership has given to this issue.

While it is important to increase the representation of Indigenous and other minority communities in research, it is also important to recognize the limits of inclusion in facilitating the accrual of concrete benefits to those communities. As I outlined in my article, the benefits of publicly funded research continue to flow mainly to large corporations, and there is little attention paid to the development of mechanisms that will return some benefit to the communities involved in large-scale screening of genomic studies.4

Genomic data are a resource, but unless we approach their use more sustainably, we risk