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– Howard Bauchner, MD, Editor-in-Chief, *JAMA*

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The JAMA Network发展

- **2012年2月：** AMA在线数据库更名为：The JAMA Network
- **2012年5月：** 新平台上线：jamanetwork.com
- **2013年3月：** APP上线: The JAMA Network Reader
- **2013年7月：** 期刊改版：JAMA Network journals
- **2013年12月：** CME部分增加离线访问功能
- **2015年2月：** *JAMA Oncology*创刊
- **2016年2月：** *JAMA Cardiology*创刊

JAMA

- **主编：**Howard Bauchner, MD
- **创刊年：**1883
- **2017年 IF:** 47.661
- **访问量：**每年超过144万次访问次数
- **发行量：**32万家纸本用户
- **出版内容：**世界上发行范围最广的综合性医学杂志。主要刊载临床及实验研究论文，还包括编者述评、读者来信等文章，除主要关注临床医学外，还涉及卫生保健、政治、哲学、伦理、经济、历史等非临床信息。此外，期刊注重教育职能，设有CME栏目，向临床医师提供基础医学与临床医学方面的继续教育服务。

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1 Research

- Clinical trials
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Original Investigation

Emergency Department Resource Use by Supervised Residents vs Attending Physicians Alone

Stephen R. Pitts, MD, MPH; Sofie R. Morgan, MD, MBA; Justin D. Schrager, MD, MPH; Todd J. Berger, MD

IMPORTANCE Few studies have evaluated the common assumption that graduate medical education is associated with increased resource use.

OBJECTIVE To compare resources used in supervised vs attending-only visits in a nationally representative sample of patient visits to US emergency departments (EDs).

DESIGN, SETTING, AND PARTICIPANTS Cross-sectional study of the National Hospital Ambulatory Medical Care Survey (2010), a probability sample of US EDs and ED visits.

EXPOSURES Supervised visits, defined as visits involving both resident and attending physicians. Three ED teaching types were defined by the proportion of sampled visits that were supervised visits: nonteaching ED, minor teaching ED (half or fewer supervised visits), and major teaching ED (more than half supervised visits).

MAIN OUTCOMES AND MEASURES Association of supervised visits with hospital admission, advanced imaging (computed tomography, ultrasound, or magnetic resonance imaging), any blood test, and ED length of stay, adjusted for visit acuity, demographic characteristics, payer type, and geographic region.

RESULTS Of 29 182 ED visits to the 336 nonpediatric EDs in the sample, 3374 visits were supervised visits. Compared with the 25 808 attending-only visits, supervised visits were significantly associated with more frequent hospital admission (21% vs 14%; adjusted odds ratio [aOR], 1.42; 95% CI, 1.09-1.85), advanced imaging (28% vs 21%; aOR, 1.27; 95% CI, 1.06-1.51), and a longer median ED stay (226 vs 153 minutes; adjusted geometric mean ratio, 1.32; 95% CI, 1.19-1.45), but not with blood testing (53% vs 45%; aOR, 1.18; 95% CI, 0.96-1.46). Of visits to the sample of 121 minor teaching EDs, a weighted estimate of 9% were supervised visits, compared with 82% of visits to the 34 major teaching EDs. Supervised visits in major teaching EDs compared with attending-only visits were not associated with hospital admission (aOR, 1.15; 95% CI, 0.83-1.58), advanced imaging (aOR, 1.21; 95% CI, 0.96-1.53), or any blood test (aOR, 1.02; 95% CI, 0.79-1.33), but had longer ED stays (adjusted geometric mean ratio, 1.32; 95% CI, 1.14-1.53).

CONCLUSIONS AND RELEVANCE In a sample of US EDs, supervised visits were associated with a greater likelihood of hospital admission and use of advanced imaging and with longer ED stays. Whether these associations are different in EDs in which more than half of visits are seen by residents requires further investigation.

JAMA. 2014;312(22):2394-2400. doi:10.1001/jama.2014.16172

Supplemental content at jama.com

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Case Report/Case Series

Novel Genetic Mutations in a Sporadic Port-Wine S

Christine Guo Lian, MD; Lynette M. Sholl, MD; Labib R. Zakka, MA, MD; Teresa M. O, MD; Cynthia Liu; Shuyun Xu, MD, PhD; Ewelina Stanek; Elizabeth Garcia, PhD; Yonghui Jia, PhD; Laura E. MacConaill, PhD; George F. Murphy, MD; Milton Waner, MD; Martin C. Mihm Jr, MD

IMPORTANCE Port-wine stains (PWSs) are common congenital cutaneous capillary malformations. A somatic *GNAQ* mutation was recently identified in patients with sporadic PWSs and Sturge-Weber syndrome. However, subsequent studies to confirm or extend this observation are lacking.

OBSERVATIONS We report a long-standing, unilateral facial PWS of a man in his early 70s confirmed by histopathological analysis. Staged surgical excision of the vascular malformation was performed, and genomic DNA was extracted from the vascular malformation specimen and normal skin. Targeted next-generation sequencing of the coding sequence of 275 known cancer genes including *GNAQ* was performed in both specimens. A single-nucleotide variant (c.548G>A, p.Arg183Gln) in *GNAQ* was identified in the PWS-affected tissue but not in the normal skin sample. In addition, this sequencing approach uncovered several additional novel somatic mutations in the genes *SMARCA4*, *EPHA3*, *MYB*, *PDGFR-β*, and *PIK3CA*.

CONCLUSIONS AND RELEVANCE Our findings confirm the presence of somatic mutations in *GNAQ* in the affected skin of a patient with congenital PWS, as well as alterations in several other novel genes of possible importance in the pathogenesis of PWS that may also offer substantial therapeutic targets.

JAMA Dermatol. 2014;150(12):1336-1340. doi:10.1001/jamadermatol.2014.1244
Published online September 3, 2014.

Port-wine stains (PWSs), or capillary malformation, are a common type of cutaneous vascular malformation with a prevalence of 0.3% to 0.5%.[1,2] Clinically, PWS often involves the head and neck as an isolated pink flat lesion that becomes darker and may thicken over time.[1] Port-wine stains may be part of a syndrome, including Sturge-Weber syndrome among others.[1] A long-standing hypothesis that PWSs are associated with an underlying somatic mutation was supported in a recent study. Twelve of 13 patients with nonsyndromic PWSs showed a mutation in a single-nucleotide variant (c.548G>A, p.Arg183Gln) in the *GNAQ* gene (OMIM 600998).[3]

In this report on a patient with a long-standing PWS lesion, we document the presence of a *GNAQ* c.548G>A mutation. Importantly, several novel mutations in the *SMARCA4*, *EPHA3*, *MYB*, *PDGFR-β*, and *PIK3CA* genes were also identified, extending the scope of mutational anomalies in this condition.

Report of a Case

A healthy man in his early 70s presented with a predominantly unilateral congenital facial vascular lesion. Physical examination revealed painless, dark red to violaceous macules,

patches, coalescent plaques, and noo
his face (Figure 1). There was marke
lateral lower lip, right cheek, righ
(Figure 1). The lesion also extended to
terior neck. A clinical diagnosis of PW
Weber syndrome was ruled out by ap
previously received laser and surgic
cently a staged surgical excision of th
pertrophy over a 6-month period, du
biopsy of the previously untreated au
diameter sample of normal skin area

Histopathological Analysis

Compared with the normal skin sa
study of the auricular nodule showe
dilatation of papillary dermal capilla
ules, and small veins in the supe
(Figure 2A). The abnormal vascular
ferent sizes and shapes throughou
(Figure 2A). The superficial abnorm
walls (Figure 2A), in contrast to the th
aspects of large vessels (Figure 2B). Those larger ectatic structures had thickened walls with multiple duplications of the basement membrane zones and entrapment of pericyte-like cells in the thickened areas (Figure 2B). The endothelial cells

Letters

RESEARCH LETTER

Non-English-Language Proficiency of Applicants to US Residency Programs

More than 25 million US residents have limited English proficiency, an 80% increase from 1990 to 2010.[1] Limited English proficiency (LEP) may impede participation in the English-language-dominant health care system.[2] Little is known about the non-English-language skills of physicians in training. This study characterizes the language diversity of all US residency applicants through the Electronic Residency Application Service and contrasts applicant language skills with the predominant languages of the US population with LEP.

Methods | Applicants were asked to self-report proficiency in all languages spoken using the Interagency Language Roundtable scale adapted for physicians for the first time in 2013.[3]

Table. 2013 Residency Applicants by Ethnic Self-Identity and Citizenship/Immigration Status

	Total (N = 52 892)	Applicants, %	Languages Spoken, %[a] English Only	2	>2	At Least Advanced Proficiency of NEL, %
Ethnic Self-Identity[b]						
Latino	2800	5.3	1.4	73.6	25.0	91.4
Peruvian	166	0.3	0	63.3	36.8	98.2
Dominican	178	0.3	0	72.5	27.5	98.3
Colombian	279	0.5	0.4	74.6	25.1	96.0
Puerto Rican	594	1.1	1.2	85.4	13.5	96.4
Other Hispanic, Latin	743	1.4	1.2	59.6	39.2	94.4
Cuban	232	0.4	1.3	86.6	12.1	90.4
Mexican, Mexican American	608	1.1	3.1	77.1	19.7	76.7
Asian						
South Asian	10 430	19.7	2.1	14.0	84.0	82.6
Bangladeshi	308	0.6	0.3	22.4	77.3	89.3
Pakistani	1842	3.5	0.8	14.9	84.3	90.4
Indian	8280	15.6	2.4	13.5	84.1	80.5
Other	5548	10.5	4.3	48.1	47.6	68.9
Vietnamese	596	1.1	2.7	51.7	45.6	64.7
Taiwanese	404	0.8	2.7	41.6	55.7	59.8
Chinese	1812	3.4	2.9	56.7	40.4	69.0
Other Asian	1088	2.1	3.6	35.2	61.2	82.1
Korean	816	1.5	6.3	43.6	50.1	60.3
Filipino	668	1.3	7.5	49.9	42.7	64.4
Japanese	164	0.3	11.0	58.5	30.5	78.8
Black/African American	3376	6.4	27.7	47.9	24.4	56.1
Other black or African	143	0.3	16.1	39.2	44.8	65.0
African	1372	2.6	19.7	54.5	25.8	78.6
Afro-Caribbean	518	1.0	24.1	33.2	42.7	54.7
African American	1343	2.5	38.5	47.7	13.9	25.9
White	21 077	39.8	27.9	50.9	21.3	31.3
Other	1722	3.3	8.3	44.8	47.0	74.9
No identity response[c]	8029	15.2	10.2	41.6	48.3	61.0
Citizenship/Immigration Status						
Non-US citizens	15 219	28.7	3.6	32.9	63.5	93.0
Legal alien[d]	7227	13.6	3.0	28.3	68.7	93.4
US permanent resident	5126	9.7	3.3	38.7	58.0	94.8
Non-US-based applicant	2866	5.4	5.6	34.0	60.4	88.7
US citizen	37 763	71.3	20.4	46.7	32.9	42.2

Abbreviation: NEL, non-English language.

[a] Percentages may not equal 100% due to rounding.

[b] Self-identity categories with at least 100 responses are shown; only the top 68% (23/34) of self-identity categories are listed. Obtained via self-report from predetermined categories on the application and was included to comment on different language abilities among different ethnic groups. The application asked participants "How do you self-identify? Please select all that apply." Subgroup rows ordered by percentage speaking English only (low to high).

[c] Applicants who were citizens of a European country were instructed to select "Prefer not to say."

[d] Refers to an individual who entered the United States legally (eg, entered the United States on a student visa).

2 Opinion

- Viewpoints
- Dueling Viewpoints
- Editorial
- Commentary
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Opinion

EDITORIAL

Substance Misuse Among Adolescents
To Screen or Not to Screen?

Geetha A. Subramaniam, MD, DFAPA; Nora D. Volkow, MD

Related article page 822

Opinion

VIEWPOINT

Global Tuberculosis
Perspectives, Prospects, and Priorities

Thomas R. Frieden, MD, MPH
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Anthony D. Harries, MD, FRCP
International Union Against Tuberculosis and Lung Disease, Paris, France, and London School of Hygiene and Tropical Medicine, London, United Kingdom.

Opinion

VIEWPOINT

Public Health in the Age of Ebola in West Africa

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3 Clinical Review & Education

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Clinical Review & Education

Review

Traveler's Diarrhea
A Clinical Review

Robert Steffen, MD; David R. Hill, MD, DTM&H; Herbert L. DuPont, MD

IMPORTANCE Acute diarrhea is the most common illness that affects t
regions of the world. Although improved hygiene has reduced the risk
many destinations, the risk remains high in others.

OBJECTIVE To review the current state of knowledge on the etiology,
and management of traveler's diarrhea.

EVIDENCE REVIEW A search of the PubMed, Google Scholar, and Coch
for the period 2012–April 2014 was performed for articles on traveler'
search yielded 2976 articles, of which 37 were included in this review.
85 articles previously identified by the authors.

FINDINGS Improved hygiene has reduced the risk of traveler's diarrhe
(for a 2-week stay) to between 8% and 20% in some parts of
's diarrhea causes 12% to 46% of travelers to change their trav
rs seeking medical care have a diagnosis of gastrointestinal dist
imately one-third of all cases. Postinfectious irritable bowel sy
in 3% to 17% of patients who have had traveler's diarrhea. Prev
a by dietary avoidance measures is often not successful. Chem
be restricted to travelers who are at risk of severe complicatio
loxacin is the standard treatment in self-therapy of traveler's di
when patients are in South or Southeast Asia, where azithrom
erred.

USIONS AND RELEVANCE Diarrhea remains a common problem
rs. Persons intending to travel to at-risk countries should be co
tion measures and may be given a travel pack that includes me
eatment should they become ill.

015.313(1):71-80. doi:10.1001/jama.2014.17006

despite the description of the syndrome of traveler's diar-
hea more than 50 years ago by B. H. Kean,[1] the discov-
ery of enterotoxigenic *Escherichia coli* (ETEC) as a
ogy a decade later,[2] and effective treatment soon
,[3] the incidence of traveler's diarrhea during a 2-week
ns 10% to 40%, depending on destination and traveler
istics. In addition, the GeoSentinel database, a global
of clinics sharing data about travel-related morbidity,
ted that acute and chronic diarrhea accounted for 335 of
0 medical visits by returned travelers.[4] Reduction in
ence of traveler's diarrhea is more closely related to
of sanitation at the destination rather than specific
ons implemented by the traveler.[5] Therefore, travelers
e prepared to manage illness that may occur during their
seas.

JAMA Clinical Challenge

A 38-Year-Old Man With Extensor Surface Papules

Eric Melnychuk, DO, EMT-B; Alexis Weymann Perlmutter, MD, MEd; Eric Hossler, MD

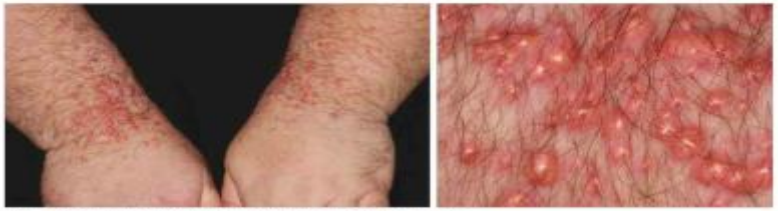

Figure 1. Left, Erythematous pink-and-yellow papules on the wrists. Right, Close-up of the papules.

A 38-year-old morbidly obese man presents with a 1-month history of rash on the extensor surfaces of his hands, forearms, elbows, shoulders, flanks, and upper thighs. The rash is nonpruritic but is associated with burning pain. The patient has had no fevers, shortness of breath, recent viral syndromes, or recent travel. He has a history of pancreatitis several years prior, recent repair of a tibial fracture, ankle osteoarthritis, cholelithiasis, seizure disorder, and bipolar disorder. He has a family history of type 2 diabetes in his father and brother. His current medications include phenobarbital, levetiracetam, quetiapine, lorazepam, fluoxetine, tramadol, aspirin, celecoxib, and gabapentin, none of which were started in the past few months. Skin examination reveals hundreds of bright pink papules with central yellow hue distributed symmetrically over his dorsal hands, elbows, shoulders, and thighs (**Figure 1**). The remainder of the examination is unremarkable.

Quiz at jama.com

WHAT WOULD YOU DO NEXT?

A. Obtain a lipid panel

B. Order a chest radiograph

C. Treat empirically with oral prednisone

D. Unroof one of the papules and send for viral culture

JAMA PATIENT PAGE | Infectious Diseases

Traveler's Diarrhea

Traveler's diarrhea is the most common illness among persons visiting lower-income countries.

What Is Traveler's Diarrhea?

Traveler's diarrhea is an illness mostly caused by bacteria in food or water. If you have traveler's diarrhea, your main symptom will be loose stools. Stomach cramps and nausea are also common. You also might have vomiting or fever.

If you are a healthy adult, traveler's diarrhea will probably not be serious. But you might have to change your travel plans until you recover. Without treatment, most people recover within 4 days.

How Can I Avoid Traveler's Diarrhea?

To avoid getting traveler's diarrhea, you should

- Wash your hands often. This is especially important after you use the bathroom or before you eat. Use lots of soap and water.
- Be careful what you eat or drink.
  - Try to choose restaurants that are busy and clean. Try to avoid buffets. Food should be recently cooked and served very hot.
  - Avoid raw fruits and vegetables. (But these might be safe if they are peeled or washed in clean water.)
  - Avoid undercooked meats, fish, and seafood.
  - Avoid tap water and ice. (Ice might have been made with unclean water.)
  - Choose beverages in factory-sealed containers. Bottled water is a good example. Beverages made using boiling water are also safe. Tea is a good example.

How Can I Treat My Traveler's Diarrhea?

If you develop traveler's diarrhea, you should drink lots of fluids. This is especially important for young children. It is also especially important if you are older or have a chronic illness.

Make sure the fluids are safe (see above). Tea with some sugar is a good choice. Soup is another good choice. If you are dizzy, eat salted crackers. In serious cases, you can drink a solution made from a powder you can buy in drugstores worldwide. These solutions can help prevent dehydration. They are also helpful in children or in adults with medical conditions.

You might also consider packing an antibiotic. The choice of antibiotic will depend on where you are going. You should ask your doctor or travel clinic for help choosing.

Drugs are available that can stop diarrhea for a short time (for example, loperamide). Because these drugs stop diarrhea, you can board a bus or plane until an antibiotic starts working.

What If I Still Have Traveler's Diarrhea After I Get Home?

You should see your doctor or travel clinic if you still have traveler's diarrhea for more than 72 hours after you get home. This is especially important if you are seriously ill or if you have a fever or blood in your stool.

FOR MORE INFORMATION

- Centers for Disease Control and Prevention
  www.nc.cdc.gov/travel/page/travelers-diarrhea

Authors: Robert Steffen, MD; David R. Hill, MD, DTM&H, FRCP, FFTM; Herbert L. DuPont, MD

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Steffen reports receipt of consulting fees/honoraria and support for travel from Dr Falk Pharmaceuticals and payment for lectures/speakers bureaus and support for travel from various vaccine producers unrelated to traveler's diarrhea. Dr DuPont reports consultancy for Salix Pharmaceuticals and Cubist and payment for lectures/speakers bureaus from Merck, Cubist, and Salix Pharmaceuticals (paid to him) as well as consultancy for Merck and GlaxoSmithKline and grants from Sanofi Pasteur, GlaxoSmithKline, and Viropharma (paid to his institution). Dr Hill reported no disclosures.

Source: Centers for Disease Control and Prevention

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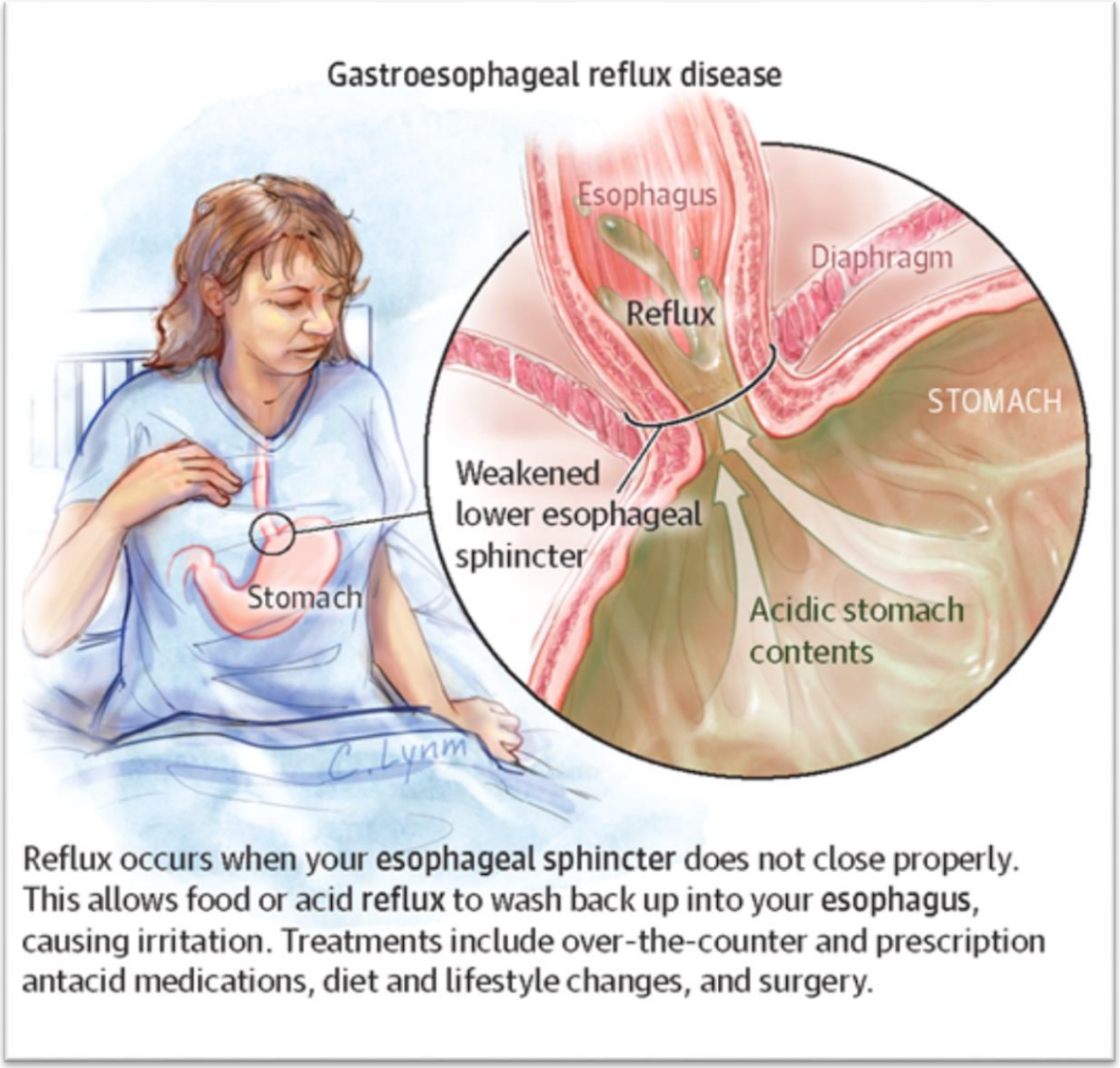

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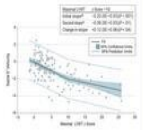

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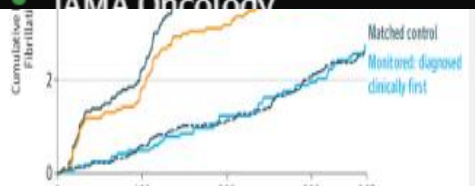

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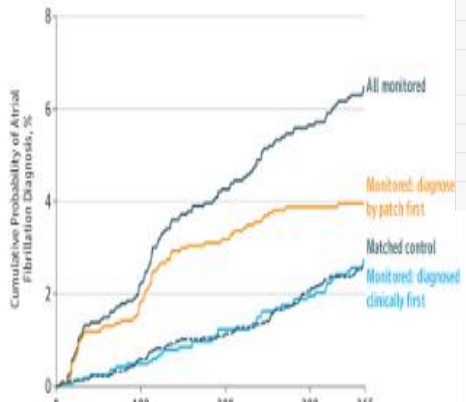

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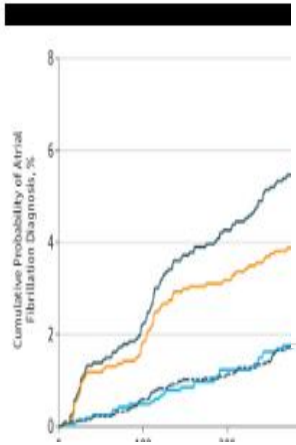

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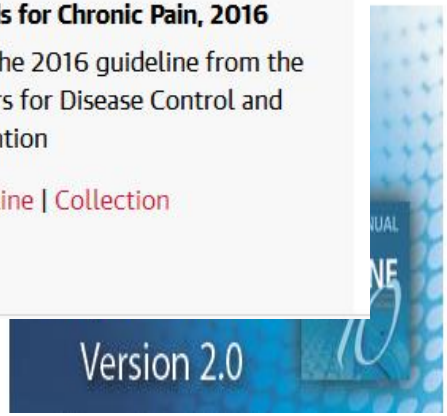

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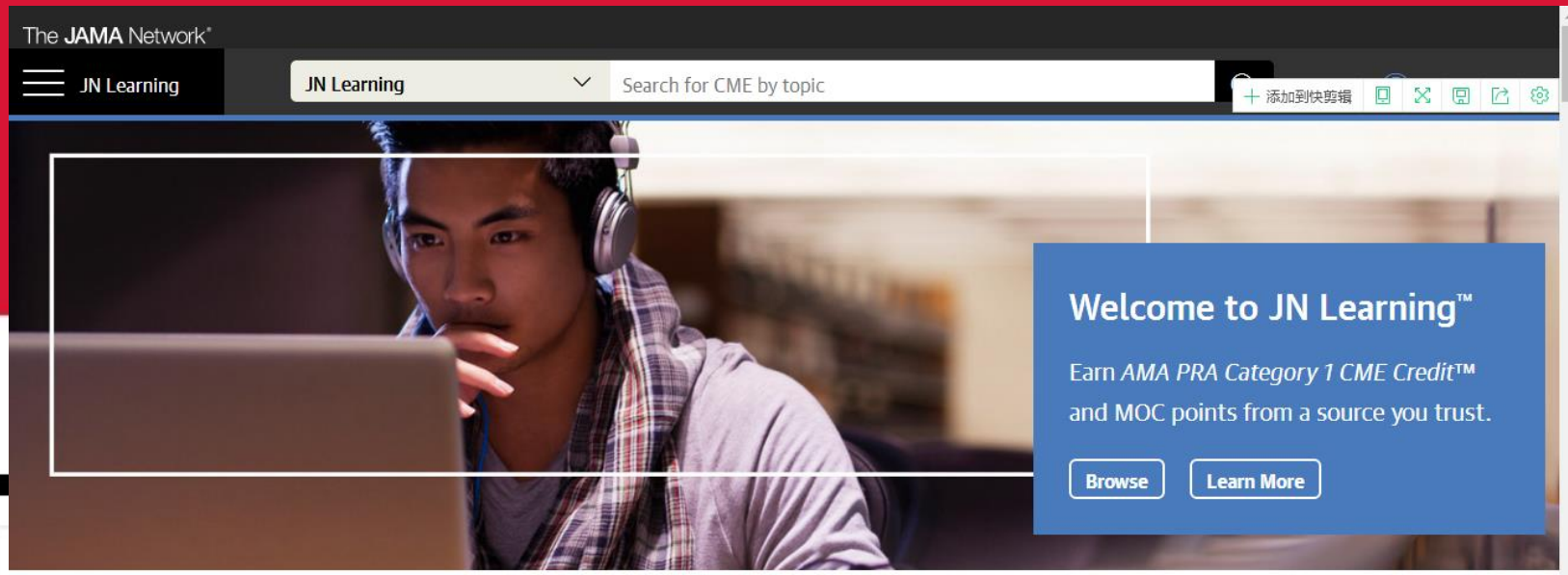

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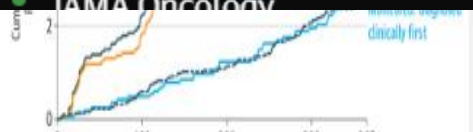

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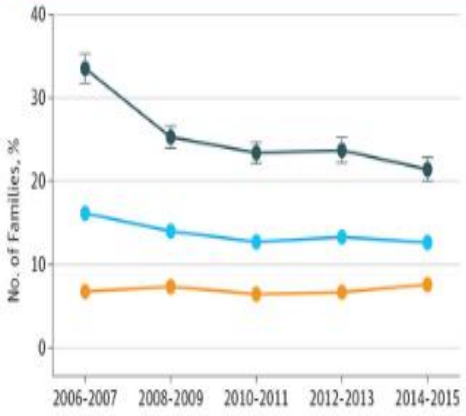

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Early Phenotypes and the Influence of Left Ventricular Wall Thickness

Carolyn Y. Ho, MD; Sharlene M. Day, MD; Steven D. Colan, MD; et al

Feb Research

Life Expectancy in Patients With Type 1 Diabetes

Historically, type 1 diabetes mellitus has been associated with large reductions in life expectancy. Livingstone and colleagues assessed life expectancy in a contemporary cohort of 24 691 Scottish patients with type 1 diabetes and found that compared with the general population, subsequent life expectancy at age 20 years for patients with diabetes was approximately 11 years less for men and 13 years less for women. In an Editorial, Katz and Laffel discuss prevention of diabetes complications to improve patient survival.

Editorial and Related Article

Intensive Treatment of Diabetes and Long-term Mortality

In an observational follow-up of participants in the Diabetes Control and Complications Trial, which involved random assignment to intensive treatment (n=711) or conventional treatment (n=730) for a mean 6.5 years and intensive treatment for all participants recommended thereafter, Orchard and colleagues found that mortality risk was modestly lower among individuals in the initial intensive therapy group after a mean 27 years' follow-up.

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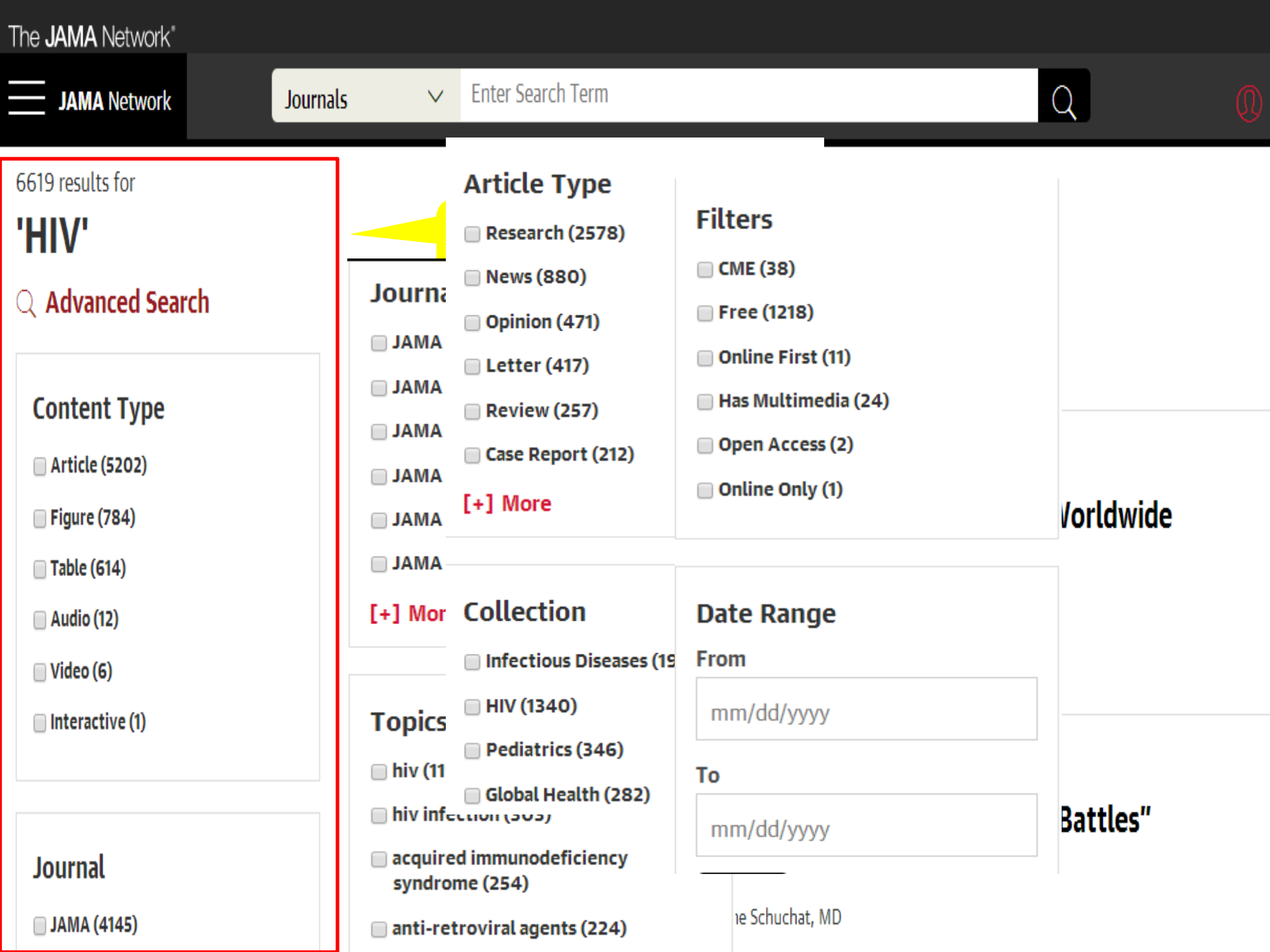
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Thank you!

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