Chronic heart failure

Dear Editor

The recent article by Andrew Sindone and Chris Naoum[1] (*AFP* December 2010) makes several errors that deserve mention. All relate to the failure to differentiate systolic from diastolic heart failure.

Angiotensin converting enzyme inhibitors (ACEIs), angiotensin II receptor blockers (ARBs) and beta blockers are not indicated in diastolic heart failure as they have (in the case of ACEIs and ARBs) been demonstrated not to effective in preventing morbidity and mortality, and in the case of beta blockers, have not been studied.

Australia is suffering an epidemic of diastolic heart failure, especially in the elderly, where comorbid frailty means the potential for harm (such as falls) from inappropriate prescription of these agents is high.

Perhaps in the authors' practice this is infrequently observed; in mine it certainly is not.

Peter Lange
Geriatrician
The Royal Melbourne Hospital, Vic

Reference

1. Sindone A, Naoum C. Chronic heart failure: improving life with modern therapies. Aust Fam Physician 2010;39:898–901.

Reply

Dear Editor

We thank Peter Lange for his comments. There is really no data to base his or my opinions regarding heart failure with preserved systolic function. It is an evidence free zone and the few studies into this area have shown no benefit of any of the treatments used.

It is a source of frustration that we have no proven therapy for heart failure with preserved systolic function at present.

Andrew Sindone
Director, Heart Failure Unit and Department of Cardiac Rehabilitation
Concord Hospital, NSW

Chris Naoum
Department of Cardiology
Concord Hospital, NSW

Eligibility criteria for the venesection service

Dear Editor

Thank you to Dr Allen for her article on hereditary haemochromatosis[1] (*AFP* December 2010).

I wish to clarify some of the eligibility criteria for the venesection service provided by the Australian Red Cross Blood Service (the Blood Service). In regard to haemochromatosis or iron overload, eligibility is based on:

- hereditary haemochromatosis (homozygous or compound heterozygous), or
- evidence of iron overload (elevated transferrin saturation or other investigations consistent with iron overload), and
- must be free of hepatitis B, hepatitis C and HIV, and
- must fulfil Blood Service donor guidelines from a health perspective (eg. patients with cardiac disease, vascular disease, poorly controlled diabetes or renal failure are not eligible).

Patients with an elevated ferritin who do not have hereditary haemochromatosis or iron overload (including those heterozygote for a single HFE gene) are not eligible for the Blood Service therapeutic venesection program.

They may be eligible to donate as normal blood donors if other causes of raised ferritin, such as malignancy, significant liver disease, chronic systemic or inflammatory disease or autoimmune disease, have been excluded.

For further information regarding the therapeutic venesection service and for access to request forms, please refer to our website at www.transfusion.com.au/iTransfuse/resources/forms#forms_therapeutic. The referral should be accessed and approved by the Blood Service before the patient's initial presentation.

Any queries can be directed to a Blood Service medical officer on 131495.

Barbara Bell
National Medical Services Manager
Australian Red Cross Blood Service

Reference

1. Allen K. Hereditary haemochromatosis: diagnosis and management. Aust Fam Physician 2010;39:838–41.

Prescribing opioid substitution therapy

Dear Editor

I read with great interest and reassurance the recent article by Scarborough et al[1] (*AFP* April 2011) about opioid substitution therapy (OST) in general practice. It resonated clearly with my own experiences. For the past two and a half years I have been practising in a locality with a sizeable drug misuse problem, be it licit drugs, illicit drugs or diverted prescription medication.

After a few months of commencing work here, I decided to undertake the prescriber course under the auspices of the Department of Human Services Victoria. It started out trouble free enough, as my first patient was stable on the program for several years and functionally well adjusted. Over the next 18 months, I was prescribing for a maximum of 10 patients at any given time. If the issue of my involvement on the program was viewed in isolation, I had no major objections. Sure the bureaucratic impositions were onerous, but they were necessary. Some patients posed a minor inconvenience with missed doses, requiring unplanned clinical reviews, and some were clearly not committed from the outset, dropping out after a few days.

However, some of these patients were misusing other prescribed drugs of dependence (DD), namely benzodiazepines, and were exerting pressure on me to prescribe these as well. As word spread locally and beyond that I was an OST prescriber, I found myself accumulating a cohort of patients outside of the program per se, who were purportedly initially suffering from a chronic pain and/or psychiatric disorders, but had developed a dual diagnosis with prescription DD misuse. I felt obliged to do something to stabilise them, as they gave the impression of being sent from pillar to post by other GPs who did not want to get their 'hands dirty' by accepting responsibility for their long term management.

This was to prove my undoing. My attempts to instil some discipline and control of their drug use were constantly subverted by their inability to comply with my plans, and it became apparent that they just expected me to be their drug peddler. They were disruptive and demanding, expecting priority attention, and I was frequently faced with aberrant behaviour such as unsanctioned dose escalations and reportedly lost and stolen scripts and medications. Countless hours of unremunerated work were spent dealing with their telephone interruptions, negotiating rational dispensing arrangements with pharmacies and liaising with regulatory and advisory bodies.

Ultimately, this all contributed to a decline in my mental health and work performance. My ability to provide general medical care to patients without drug misuse problems was being undermined and compromised. My senior practice colleagues and practice manager intervened and instructed me to revoke my OST licence and restrict the scope of my prescription of DD within strict limits. This peer review process was in the best interests of risk management at a personal and practice level.

My conclusion is that it is seemingly too difficult to integrate a cohort of patients with substance use problems into mainstream general practice, as well meaning as this intention may be. One strategy employed by some GP colleagues is to clearly delineate their workload, by seeing general medical patients in a standard clinic setting, and dealing with drug misusing patients in a separate more appropriate setting such as an addiction medicine facility or community health centre. At least I can take solace in the fact that in the eyes of the authors at least, I deserve credit for having a crack at a very difficult nut indeed!

Prashanth Pawar
Melton, Vic

Reference

1. Scarborough J, Eliott J, Braunack-Mayer A. Opioid substitution therapy: a study of GP participation in prescribing. Aust Fam Physician 2011;40:241–5.

Patients with Down syndrome

Dear Editor

I read with great interest the guest editorial[1] and article by Jane Tracy[2] (*AFP* April 2011) which summarised the healthcare issues for patients with Down syndrome. Although the article considered issues across the patient's lifespan, advanced care planning was not discussed.

General practitioners are ideally placed to integrate and coordinate both aspects of care planning with symptom and end of life management and decision making in advanced care.[3] With the high incidence of medical comorbidity and concomitant causes of premature mortality, specialist palliative care services and advice are often required to assist carers, families and guardians, disability workers and GPs to maintain care for the Down syndrome patient in their community or residential setting.

The timely access to bereavement care for the surviving family members, which is also provided by palliative care, may be lost but is of particular importance as the bereavement period is often flavoured with life long issues of grief and loss connected to the patient's underlying condition.[4]

Mark Boughey
Director of Palliative Medicine
St Vincent's Hospital, Melbourne, Vic

References

1. Tracy J. People with disabilities: a rewarding challenge in general practice. Aust Fam Physician 2011;40:181.
2. Tracy J. Australians with Down syndrome: health matters. Aust Fam Physician 2011;40:202–8.
3. Mitchell G, Johnson C, Thomas K, Murray S. Palliative care beyond cancer for Australians. Med J Aust 2010;193:124–6.
4. Hodapp RM. Families of persons with Down syndrome: new perspectives, findings, and research and service needs. Ment Retard Dev Disabil Res Rev 2007;13:279–87.

Medical specialists for adults with disabilities

Dear Editor

In her guest editorial on people with disabilities (*AFP* April 2011), Dr Jane Tracy[1] stated there is (as yet) no equivalent medical specialists for adults with disabilities. This statement is not correct. Fellows of the Faculty of Rehabilitation Medicine (Royal Australasian College of Physicians) are working in Australia and New Zealand with adults with developmental and acquired disabilities.

There are perhaps inadequate numbers of our faculty, and there are difficulties meeting the needs of adults with developmental and acquired disability due to funding and resource limits. However, there are a group of physicians supported by their faculty and college with an interest in this field of medicine.

Many paediatricians working with disabled children are also members of the faculty; the transition of young people with disability from paediatric to adult specialist medical services in particular is of concern. The pivotal role of the general practitioner is recognised, but they are not alone.

Adrian Winsor
Adelaide, SA

Reference

1. Tracy J. People with disabilities: a rewarding challenge in general practice. Aust Fam Physician 2011;40:181.

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