Gaps in practice

Dear Editor

The excellent editorial by Carolyn O'Shea[1] (*AFP* January/February 2011) omits one important gap, that of unorganised illness. Balint[2] described this well, but as a College we have tended to ignore it in our assessment processes. Yet many of the presentations to general practice, in the first instance, are vague patterns of illness that do not fit into a recognisable pattern that we have been taught. Sometimes it will take a number of consultations before an established pattern of illness appears, or it may never appear and the patient may recover, or as often happens the patient may gradually disclose, over a period of time, the reason that they became unwell. This can be overcome by giving more time to the patient.

It is important to realise that in the first instance it may be impossible to reach a diagnosis that is evidence based, as is pointed out in the editorial. Therefore it is just as important that we, as general practitioners, develop the clinical skills that are necessary to define the gravity of the presentation and to recognise how urgent it may be to form a plan of management, without necessarily reaching a diagnosis, before referring the patient on. It is a brave general practitioner, who of their own volition undertakes a plan of management without some evidence base for their diagnosis.

This, in my opinion, is the true skill of general practice.

Eric Fisher
Sydney, NSW

References

1. O'Shea C. Gaps, holes and change. Aust Fam Physician 2011;40:5.
2. Balint M. The doctor, his patient and the illness. London: Tavistock Publications,1973.

Complementary medicine

Dear Editor

I feel some feedback is warranted on the article on complementary medicine by Pirotta et al[1] (*AFP* December 2010).

Is it just me, or are there other GPs out there who object to being labelled 'nonintegrative medicine GPs'?

I feel that I practise a very holistic style of medicine, addressing lifestyle issues, psychological issues and utilising all substances known to humanity that have been proven to benefit patient wellbeing.

I do not discriminate between 'conventional medicines' or 'herbal compounds'. If they have been proven to work in double blind placebo controlled trials then I will recommend them. This is the basis of evidence based medicine. This is how today's willow bark and foxglove become tomorrow's aspirin and digoxin.

My style of medicine integrates all modalities of the current understanding of the body and mind, and yet I feel I would be labelled 'nonintegrative' by the writers of this article.

We seem to forget that there is a word for 'complementary medicine' that has been proven efficacious in scientifically conducted trials; the word is 'medicine'.

Paul Holownia
Brisbane, Qld

Reference

1. Pirotta M, Kotsirilos V, Brown J, Adams J, Morgan T, Williamson M. Complementary medicine in general practice: a national survey of GP attitudes and knowledge. Aust Fam Physician 2010;39:946–9, 953.

Reply

Dear Editor

We completely agree with Dr Holownia's sentiments. We should be aiming to have a world where all medicines (not just complementary medicines [CM]) are known to be either effective or not. Yesterday's 'alternatives' become tomorrow's mainstream once the evidence is supportive. 'Mainstreaming' of complementary therapies is already occurring here, with widespread use in the community and by GPs, and the National Health and Medical Research Council specifically encouraging more research through their funding mechanisms.

In our article,[1] for analysis purposes, we asked the GPs who kindly participated in our research to self identify as either integrative medicine (IM) or non-IM practitioners, as this term is in widespread use internationally. Our adoption in the paper of the short hand term 'non-IM GPs' was based on the participants' negative response to this specific question: 'Do you consider that you practice integrative medicine (a holistic approach to healthcare that integrates conventional medical care with complementary therapies)? Then we explored whether GPs who considered themselves as IM practitioners vary in their CM knowledge and practice with compared with GPs who did not identify as IM.

As we write in the paper, the terms 'IM' and 'non-IM GPs' were not really useful in our research context. In both groups, knowledge about commonly used CM side effects and interactions were poor.

As for the term 'integrative medicine', as Dr Holownia's letter demonstrates and we suspect our research shows, many GPs practise patient centred medicine, considering their patients in their broad psychosocial context and integrating the best available treatments, without regard to what might currently be labelled complementary. The term 'integrative medicine' means different things to different people. Even the term 'complementary medicine' is limited in its usefulness, as some previously complementary practices are adopted to various degrees by the mainstream.

Marie Pirotta, Vicki Kotsirilos, Jared Brown, Jon Adams, Tessa Morgan and Margaret Williamson

Reference

1. Pirotta M, Kotsirilos V, Brown J, Adams J, Morgan T, Williamson M. Complementary medicine in general practice: a national survey of GP attitudes and knowledge. Aust Fam Physician 2010;39:946–9, 953.

Hospital in the Home

Dear Editor

I read with interest the paper by Davidson et al[1] (*AFP* December 2010) which summarised their approach to the palliative management of end stage heart failure.

Please allow me to raise an underutilised additional tool for the management of severe, terminal heart failure. The use of intravenous iontropes (such as dobutamine or milrinone) delivered at home in this situation can be extremely effective in controlling otherwise severe symptoms, improving quality of life and preventing readmission to hospital. While initially used as a bridge until heart transplant, it is also an effective tool where transplant has been ruled out and symptom control difficult to achieve with other methods.

Such treatment is available through some Hospital in the Home Units. The benefits to the patient more than compensate for the need for a peripherally inserted central catheter (PICC) line and a small pump. The main risks are those associated with the line, arrhythmias, and increased doses due to tolerance. It is an option worth knowing about, and considering.

Michael Montalto
Royal Melbourne Hospital
Hospital in the Home, Vic

Reference

1. Davidson PM, Macdonald PS, Newton PJ, Currow DC. End stage heart failure patients: palliative care in general practice. Aust Fam Physician 2010;39:916–20.

IV iron replacement

Dear Editor

The article on IV iron replacement by Naim and Hunter[1] (*AFP* November 2010), which explores the use of bolus IV iron, demonstrates how it may be possible to treat iron deficiency in a community setting and comes at a time when there is increased focus on better management of iron deficiency.[2] Previously, the treatment of this condition through total dose iron infusions[3] relayed the message that safe, effective and rapid improvement was possible through this means.

Premenopausal women with menorrhagic iron deficiency form the bulk of the community based iron deficient population.[3] Bolus IV iron therapy would be invaluable for a subgroup of such women who are also blood donors and who suffer obligatory deferment of their blood donation as a result of their iron deficiency anaemia arising through blood donation in combination with gynaecological blood loss. It would be of great interest, in particular to the Australian Red Cross Blood Transfusion Service, if there could be a general practice initiative in the treatment of this population of women donors through this bolus IV technique.

Ram Tampi
Perth, WA

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2. Pasrichasr SS, Flecknoe-Bown SC, Allen KJ, et al. Diagnosis and management of iron deficiency anaemia: a clinical update. Med J Aust 2010;193:5252–32.
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Appointments on time

Dear Editor

In the article 'Appointments – getting it right'[1] (*AFP* January/February 2011) the point is driven that 'demand is predictable'. My own experience of 20 years in general practice is that demand is not reasonably predictable and this has led me to work with no appointments at all!

In my practice patients may get seen within a few minutes of their arrival; rarely they wait for more than half an hour.

I changed my practice decades ago after becoming frustrated with some patients not attending and having to wait for late patients. Practising with appointments is extremely inefficient in other ways too. Most of the late patients would be apologetic and would spend half of the visit time explaining why. On the other hand, when the practice schedule was behind time, I would have to explain the reasons for my being late! Unnecessary niceties would take up more than half the consultation time.

Although it may sound improbable to have a steady day without appointments this has worked well for me over the years. The beauty of not having appointments is that I can fill in the quiet times, with administration, checking results/follow ups, reading online newspapers, or writing reports or letters to the editor!

Reference

1. Knight A, Lembke T. Appointments: getting it right. Aust Fam Physician 2011;40:20–3.

Tony Marshal
Melbourne, Vic

Hepatitis A

Dear Editor

I read with interest the article by Mayer and Neilson[1] (*AFP* December 2010). Prevalence of HAV infection differs greatly in different parts of the world according to the geographic area, sanitary conditions and socioeconomic levels. There are several reports about a shifting epidemiological pattern of HAV from high prevalence to lower endemicity as a result of improved living conditions, even in underdeveloped and developing countries.[2] There are many conflicts (eg. wars) floods and crisis that can affect the access to safe water and proper disposal of waste. In this respect, there are great variations between different Middle East countries, and even between different parts of the same country, in some regions due to difference in sanitary and socioeconomic levels. More than 70% of the adult population are still anti-HAV IgG positive in Egypt, Iran, Afghanistan, Lebanon, Morocco, Pakistan, and Syria.[2] Travelling from low prevalence countries to those with higher prevalence has been reported as a causative factor.

Visitors should be aware of this infection and take care. Attention to water supply is very important as contaminated water is a potential source for the spread of HAV.[3] The risk of acquiring hepatitis E virus (HEV) is another risk in these areas.[4] Primary prevention is the cornerstone of HAV and HEV control in the region.

Seyed Moayed Alavian
Professor of Gastroenterology and Hepatology
Director of Baqiyatallah Research Center for Gastroenterology and Liver Disease
Tehran, Iran

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Address letters to

The Editor, Australian Family Physician
1 Palmerston Crescent, South Melbourne
Vic 3205 Australia
FAX 03 8699 0400 EMAIL afp@racgp.org.au