ADDRESS LETTERS TO
The Editor, Australian Family Physician
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Reducing CVD risk

Dear Editor

The article 'Reducing CVD risk – integration of clinical and laboratory criteria'[1] (*AFP* June 2008) is well written and informative. There are excellent drugs on the market and excellent evidence based studies by key opinion leaders with grants from pharmaceutical companies eager to get their share of the market.

However, when critically analysed, one wonders whether or not dyslipidaemia is exaggerated, after all, lipids, including HDL, LDL, and TG, are part of the normal spectrum of lipids in the blood and essential for normal healthy living. One also must wonder whether the various associated risk factors are also exaggerated in order to meet PBS criteria.

Are we, in Australia, in tune with the rest of the world when it comes to dyslipidaemia? Only recently, there was a debate held in the *BMJ* titled: 'Should women take a statin drug?' Half were in favour; half were not. Such divided consensuses together with the questioning of lack of pathophysiological explanation as to how blood lipids could possibly form arterial plaque remains unclear.

Current opinion is now favouring 'inflammation' of the endothelium of the arteries/heart as an important cause of CVD, and this seems to be more plausible, because of the pathogenesis of 'inflammation'. Inflammation causes destruction of the normal interior architecture of blood vessels/heart, with all its sequelae, including cholesterol rich plaque formation, with the cholesterol being from the leucocytes and other substances of inflammation. If this is so, how will treating dyslipidaemia help reduce CVD?

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Reference

1. Tognarini DP, Sullivan DR, Thomas DW, Sikaris K, McNeil AR, Meerkin M, Appleton CA. Reducing CVD risk – integration of clinical and laboratory criteria. Aust Fam Physician 2008;37:422–7.

EPC care plans

Dear Editor

The letter from Paul Hartigan (*AFP* July 2008)[1] states that the intended purpose of EPC care plans is to 'enable GPs to shift from short term, episodic fragmented care to whole person care that is integrated with health care providers'. I wonder if this may be something of an insult to many GPs pre-EPC chronic disease management skills? Further, he suggests that this means that care plans are not necessarily intended to improve the management of chronic disease, presumably because this wasn't explicitly stated. The information which he quoted was taken from the report by Wilkinson et al.[2] To some this may be an exciting revelation, however I am having difficulty rationalising why on earth one would wish to submit to the requirements of EPC chronic disease care plans if the intention wasn't to improve the management of chronic disease.

John Hunt
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References

1. Hartigan P. Chronic disease management. Aust Fam Physician 2008;36:503.
2. Wilkinson D, Mott K, Morey A, et al. Evaluation of the Enhanced Primary Care (EPC) Medicare benefits Schedule (MBS) items and the General Practice Education, Support and Community Linkage Program (GPESCL) evaluation final report. Canberra: Commonwealth of Australia, 2003.

LEGS study

Dear Editor

It has been brought to our attention that some GPs involved in the recruitment process for the Long term Evaluation of Glucosamine Sulphate (LEGS) study have been concerned that costs are being shifted to the public purse through Medicare. This is not the case.

The study is funded by the NHMRC and this includes paying for the knee X-rays and MRIs. Reimbursement is also available to GPs once their patients have been randomised to this placebo controlled trial. General practitioners willing to monitor and report any adverse medical events in their patients are invited to invoice the study.

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