Shoulder pain

Dear Editor

I was surprised that in the article by Masters and Burley[1] (*AFP* June 2007) they did not mention the accuracy of physical diagnostic tests in the diagnosis of partial and full thickness tears, as published by Murrell.[2] This accuracy has increased the diagnostic abilities of GPs to that of MRI (which has limited availability to GPs in Australia).

It had previously been noted that the accuracy and usefulness of determining the exact location of the lesion in chronic shoulder complaints in primary care, based on physical examination, is doubtful.[3] Therefore in this context, Murrell's work, which indicates that supraspinatus weakness, weakness in internal rotation and impingement (internal or external rotation or both) has a 98% post-test probability in diagnosing partial or full thickness tears is good news – in at least this sub-section of rotator cuff disorders.

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Reply

Dear Editor

The significance of clinical features in shoulder pain is an important point and certainly deserves further discussion. Murrell's[1] article was considered by the Australian Acute Musculoskeletal Pain Guidelines Group which I was involved with in 2003, and which resulted in the NHMRC publication *Evidence based management of acute musculoskeletal pain*.[2] The conclusion of this group was as stated in the shoulder pain article: 'there are no clinical tests that are both reliable and valid for any specific clinical entity'.

Murrell's study showed a correlation between three clinical tests: supraspinatous weakness, weakness in external rotation and positive impingement; and the chance of an arthroscopic finding of partial or complete rotator cuff tear. It is important to note that an arthroscopic finding is not the equivalent of a clinical entity. Asymptomatic findings of partial or complete rotator cuff tear are not uncommon on MRI. The important questions not answered by Murrell's study, but of vital clinical relevance were: in what proportion of patients did the arthroscopic rotator cuff findings change clinical management, and was the rotator cuff tear responsible for the presenting symptoms; which tears heal with conservative management; and do partial tears need treatment?

I would respectfully submit that the research article most needed by GP's is 'Differentiation of rotator cuff tears requiring no treatment vs. conservative treatment vs. surgical treatment'.

Scott Masters
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LEAP trial

Dear Editor

Involving GPs in research is a prerequisite to improving population based primary care. General practitioners belong to a time poor professional group and, as such, time is one of their main barriers to participating in research.[1] When research depends on procedures additional to standard practice – no matter how brief – time and organisational barriers can threaten recruitment rates. Although computerised prompts are widely used for recruitment in hospital based research projects, we are not aware of any published studies that have prospectively studied their effectiveness in enhancing recruitment into primary care practice based research studies.

The Live, Eat & Play (LEAP) trial is a randomised controlled trial of a brief intervention aiming to reduce overweight in children aged 5–9 years. Recruitment to the trial required participating Melbourne GPs and staff to weigh and measure all eligible children presenting during the recruitment period. Although weighing and measuring a child takes only a very short time, this represented a substantial practice change for almost all participating GPs.

Many LEAP general practices were already using Medical Director as their prescribing, booking, and clinical notes software package. For these practices, Medical Director software designers created an electronic prompt that was activated each time the GP opened the patient record of a child aged 5–9 years. The GP selected one of six possible options ('already weighed/measured', 'declined', 'not eligible', 'consider at next visit', 'discuss and weigh/measure now', or 'cancel'), and then selected 'finish'. The prompt continued to reappear if 'cancel' or 'consider at next visit' was chosen.

Of the 66 LEAP GPs, 46 (68.7%) used Medical Director as their main patient database, and of these 25 (54.3%)

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installed the prompt. There were three main reasons why the prompt was not installed: did not want prompt (n=4); technical difficulties (n=9); and no practical value because reception staff were weighing/measuring children (n=6). Practitioners with and without the prompt did not differ significantly in age, gender or socioeconomic status. The 25 GPs using the prompt weighed and measured significantly more children for LEAP (mean 74.7, standard deviation 44.2) than the 41 who did not (mean 53.5, standard deviation 37.3; p=0.04).

These findings suggest that a computerised prompt significantly enhanced recruitment into a major primary care trial for which a systematic, universal recruitment protocol was necessary. The results may also be relevant for the implementation of any population based screening program.

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Jane Gunn, University of Melbourne, Vic

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Malaria

Dear Editor

In 'Malaria in the Australian refugee population' (*AFP* August 2007), I noted with some concern a comment regarding testing '... if the RDT is positive, it should be followed up by a thick and thin film'. RDTs/immunochromatographic malarial tests (ICTs) have a high sensitivity in diagnosing *P. falciparum* and may be appropriate as a first line screening test in field areas where access to rapid, high quality microscopy may be a limiting factor. However, in the diagnosis of malaria in Australia, microscopy of thick and thin films for malaria should be performed in parallel with the ICT and not only if the ICT is positive. Current notification definitions for malaria only include microscopy and PCR as 'definitive' criteria for a diagnosis of malaria.[1] The authors do allude to this, albeit, slightly confusingly in the next line. The ICT does have a number of limitations, including lower sensitivity in diagnosing non-*P. falciparum* infections, inability to diagnose mixed infections, lack of parasite quantification, and occasional false positives in patients with elevated serum rheumatoid factor,[2] which exclude this test as a first line screening test in the absence of microscopy.

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Reply

Dear Editor

I agree with Dr Carradice's statement that in Australia the RDT and thick and thin films are done simultaneously, and with his comments about sensitivity and notification.

I work in a remote area of Nepal where an RDT is done as a first line test, and in refugees who have had only an RDT as screening before they fly to Australia. Neither of these situations relate directly to screening in Australia and I apologise for presenting this in a confusing manner.

I also work in a remote Aboriginal community where there are only limited medical facilities. The potential for malaria to be a problem in our remote north is very real and it may be that in the future, health workers could be screening for malaria with RDTs in these areas.

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Prostate cancer

Dear Editor

The study by Madjar et al[1] makes interesting reading (*AFP* May 2007). Many of us would like to see a reduction in the morbidity and mortality caused by prostate cancer, and it is pleasing that women feel they have a role in promoting men's health. It is understandable that women 'used the examples of cervical and breast cancer to illustrate how public education campaigns have informed and empowered women in relation to their own health'.

However, a danger of extrapolating from women's experience is that some people may assume that the (generally accepted) benefits of screening mammography and Pap tests also apply to prostate cancer screening. The benefits and harms of screening for prostate cancer in asymptomatic men are still uncertain.[2] If solid evidence of benefit is to emerge, it will come from rigorous, large scale randomised controlled trials, which are still in progress.

While Madjar et al briefly acknowledge the ongoing debate about the role of screening, much of their article talks of 'early detection', and draws parallels between women's cancers and the issue of prostate cancer. Their article does not clearly discriminate between early detection by screening versus early detection of symptomatic disease. It is unfortunate that their discussion fails to clarify this distinction, and instead makes selective use of the literature to suggest 'emerging evidence' of benefit from PSA testing.

While many of the women in the study feared their partner experiencing harm due to prostate cancer, the article does not canvass women or men's thoughts about potential harms due to treatment of cancer. A previous qualitative study showed that some men who have had high PSA levels detected come to regret ever having had the test.[3] Also, while many men are in favour of attempts to detect cancer early, some may feel ambivalent about the consequences of early prostate cancer detection and treatment on their quality of life.[3]

Madjar et al state that 'men and their partner need clearer guidance from medical experts'. However, in informing men about the wisdom of prostate cancer screening, at present 'the only honest information is uncertainty'.[4] Thankfully, evidence based resources exist to help inform men and their partners of the complexities of this issue. An example of such a resource, which I find very useful in practice, was published in this journal.[5]

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