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## Hypertension

### Dear Editor

I refer to the article 'Hypertension – The difficult decisions' (*AFP* June 2013)<sup>1</sup> and suggest an alternative method of assessing out-of-office blood pressure (BP) that might help differentiate white coat hypertension (WCH) from the real thing.

I am aware that WCH can affect some 10–20% of our patients and having read the above article, I am now also aware that it is not necessarily a benign condition.

I have always felt that the traditional 24-hour ambulatory BP monitoring system, with its arm cuff automatically inflating every 15 minutes, is intrusive and annoying to the patient.

When concerned that a patient might have WCH, I have long recommended that they borrow, hire, rent or buy an electronic BP machine to take their own BP three times a day for 7 days. They then return a log of their recordings.

This procedure achieves a number of objectives. The first is that it helps to desensitise the patient for anxiety associated with having their BP measured; it provides a clear view of the patient's BP, not only during the working week, but also during a weekend and it motivates the patients to take ownership of this particular health issue.

I also suggest that the patients bring their devices with them at the follow-up consultation to compare the 'home and away' readings on their own machines.

I accept that this procedure does not provide the depth of information obtained by the 24-hour ambulatory BP monitoring method but it is, in my opinion, an excellent screening tool to sort out the wood from the trees. It is also much cheaper than referring the patients to cardiologists or even to units or clinics that provide this service directly to patients.

Importantly, it helps to move the responsibility for looking after hypertension

from the doctors to the patients, and improves medication and lifestyle compliance.

Dr Craig Lilienthal  
Sydney, NSW

### References

1. O'Callaghan CJ, Goh MY, Rong P. Hypertension – The difficult decisions. *Aust Fam Physician* 2013;42:376–79.

### Reply

#### Dear Editor

Dr Lilienthal makes a persuasive case for home BP measurement. Similar to ambulatory devices, home measurements detect white-coat and masked hypertension and provide a better estimate of cardiovascular risk than clinical measurements.

The two methods have differences. Compared to ambulatory measures, home measurements are convenient, cheaper, aid with compliance and are more widely available. On the other hand, ambulatory measurements provide information about diurnal variation and changes in blood pressure in relation to symptoms. Also, ambulatory recordings are free of reporting bias and provide a summary of measurements that lends itself towards comparisons with previous and future measurements. It may be that the best approach is to use both methods in combination.

Dr Chris O'Callaghan  
Melbourne, VIC

### Reframing chaos

#### Dear Editor

I read with interest Louise Stone's research article 'Reframing chaos – A qualitative study of GPs managing patients with medically unexplained symptoms' (*AFP* July 2013)<sup>1</sup> and would encourage readers to read the full text of the article online. Stone is to be congratulated on her research. She highlights one of the greatest common problems in general practice: the patient with medically unexplained symptoms. Too often in general practice, we try to organise a

patient's presentation into some organic illness, with which we are familiar, into a diagnosis and treatment for the ailment rather than looking for the reason why the patient is presenting. As she says, we need to shift the focus over from organic disease to broader concepts of illness.

Stone points out that sometimes the symptoms, though apparently organic, are medically unexplained. The Royal Australian College of General Practitioners' curriculum has a section on medically unexplained illness. In my opinion, Stone's article should be part of the bibliography on the subject. Stone casts pearls of wisdom such as shifting our focus from curing to healing, tolerating uncertainty and the need for a name and a remedy, shifting the focus from curing to coping with illness, managing the need for validation after agreeing that the patient is suffering and accepting responsibility for care.

This article points out that there is no loss of face or reputation when a doctor admits that the illness does not fit a diagnosis. It also saves the patient from the merry-go-round of specialist appointments and the possibility of iatrogenic illness.

Such is the role of a true generalist.

Dr Eric Fisher  
Sydney, NSW

### Reference

1. Stone L. Reframing chaos – A qualitative study of GPs managing patients with medically unexplained symptoms. *Aust Fam Physician* 2013;42:501–02. Available at: [www.racgp.org.au/download/Documents/AFP/2013/July/201307stone\\_full.pdf](http://www.racgp.org.au/download/Documents/AFP/2013/July/201307stone_full.pdf) [Accessed 22 July 2013].

### Comprehensive BMD assessment

#### Dear Editor

We would like to add voice to the conclusions of Dr Parker in the June edition of *AFP*<sup>1</sup> regarding bone mineral density (BMD) screening in the community. We agree that many patients are inadequately screened. In fact, the investigation – dual-energy X-ray absorptiometry (DXA), known commonly as 'the BMD test' – is simple and

painless. Although the importance of fractures and risk factors for osteoporosis appear well understood, a large percentage of patients are inadequately assessed. How, then, can they be treated appropriately?

Specifically, we would like to clarify two points in the algorithm adapted from The Royal Australian College of General Practitioners (RACGP) recommendations for BMD screening.<sup>2</sup> Firstly, where possible, patients with fractures should have DXA assessment (akin to patients with a significant risk factor profile). Access issues (eg. in rural locations) may make this difficult, but *Figure 1* may give the impression of a more lax approach to DXA.

In all cases, a thorough assessment comprising DXA of both spine and proximal femur (as opposed to 'DXA of spine or proximal femur') is required as there are a number of pathophysiological reasons for non-concordance.<sup>3</sup> Although osteoporosis is a generalised condition of reduced bone mass of the entire skeleton, the rate of bone turnover and bone loss is not uniform. Sites rich in trabecular bone (eg. vertebrae) are likely to be affected earlier after menopause and to a greater degree than sites rich in cortical bone (eg. femoral neck). Also, degenerative changes and aortic calcification may spuriously elevate spinal BMD. If only vertebral BMD were measured, patients with osteoporosis concurrently with osteoarthritic changes or calcified aortas might be labelled as having 'normal' BMD.

Further, the predictive ability of BMD is highest for the particular site where it is measured. Thus, prediction of hip fracture is improved by measuring the BMD of the hip rather than the spine. Preventing both types of fractures is important, further adding to the rationale for measuring both sites.

This approach to comprehensively assessing BMD is encapsulated clearly in the RACGP guidelines<sup>2</sup> and is vital to reduce mortality and morbidity at both individual and community levels.

Dr Joseph Lee and Dr Nelson Loh  
Brisbane, QLD

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1. Parker D. An audit of osteoporotic patients in an Australian general practice. *Aust Fam Physician* 2013;42:423–27.

2. The Royal Australian College of General Practitioners. Clinical guideline for the prevention and treatment of osteoporosis in postmenopausal women and older men. Available at: <http://www.racgp.org.au/your-practice/guidelines/musculoskeletal/osteoporosis/> [Accessed 26 June 2013].
3. Hamdy RC, Petak SM, Lenchik L. Which central dual X-ray absorptiometry skeletal sites and regions of interest should be used to determine the diagnosis of osteoporosis? *J Clin Densitom* 2002;5:S11–7

## Illicit drug overdose

### Dear Editor

I am writing regarding the article, 'Illicit drug overdose – Prevalence and acute management.' (*AFP* July 2013).<sup>1</sup> Wenlong Li and Naren Gunja described current epidemiology, harms and management principles related to acute overdose of illicit drugs. Although they only outline the principles of management, part of the article about treatment of 3, 4-methylenedioxyamphetamine (MDMA) overdose is not quite precise: 'Hyponatraemia and hyperthermia, when severe, should be managed aggressively with hyper-tonic saline and cooling'.

Mild, acute hyponatraemia, in most cases, if asymptomatic, does not require any particular treatment except stopping further ingestion of the drug that causes it. Many young patients party (and take MDMA) for days; in that case, chronic hyponatraemia should be expected.

On the contrary, severe hyponatraemia lasting longer than 48 hours, must be treated carefully according to guidelines to prevent serious complication and death (central pontine demyelination).<sup>2,3</sup>

Mr Bosko Susic  
Melbourne, VIC

## References

1. Li W, Gunja N. Illicit drug overdose – Prevalence and acute management. *Aust Fam Physician* 2013;42:481–85.
2. Soupart A, Decaux G. Therapeutic recommendations for management of severe hyponatremia: current concepts on pathogenesis and prevention of neurologic complications. *Clin Nephrol* 1996;46:149–69.
3. Luzzio C. Central pontine myelinolysis. 10 May 2013. Available at: <http://emedicine.medscape.com/article/1174329-overview> [Accessed 7 August 2013].

## Reply

### Dear Editor

We thank Mr Susic for his letter addressing the issue of chronic hyponatraemia. His note regarding the management of mild and

asymptomatic hyponatraemia is appropriate and agreeable. We intended to highlight severe hyponatraemia in our article (*AFP* July 2013)<sup>1</sup> as it is a serious complication quite distinct for 3,4-methylenedioxyamphetamine (MDMA) poisoning. Indeed, hyponatraemia has been implicated as a mechanism of fatality related to MDMA overdose.<sup>2,3</sup>

We would like to take this opportunity to clarify the recommended treatment according to Australian guidelines. Treatment is indicated in severe (serum sodium concentration <120 mmol/L) and symptomatic (cerebral symptoms such as seizures or altered state of consciousness) hyponatraemia. It is important to establish the duration of hyponatraemia as this dictates the rate which serum sodium concentration should be corrected. Generally, the rate of change should be no more than 0.5 mmol/L/h and 1.0 mmol/L/h for chronic and acute hyponatraemia, respectively.<sup>4</sup> Faster rates of correction puts the patient at risk of developing central pontine myelinolysis.<sup>5</sup> As for MDMA overdose, patients do not necessarily present with chronic severe hyponatraemia. Many cases have been documented where severe and fatal hyponatraemia developed after ingestion of a single dose of MDMA.<sup>3</sup>

Of course, these patients should be managed in hospital critical care units with specialist input.

Mr Wenlong Li and Dr Naren Gunja  
Sydney, NSW

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1. Li W, Gunja N. Illicit drug overdose – Prevalence and acute management. *Aust Fam Physician* 2013;42:481–85.
2. Kaye S, Darke S, Duffou J. Methylenedioxyamphetamine (MDMA)-related fatalities in Australia: demographics, circumstances, toxicology and major organ pathology. *Drug Alcohol Depend* 2009;104:254–61.
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5. Traub S, Hoffman R, Nelson L. The "ecstasy" hangover: hyponatremia due to 3,4-methylenedioxyamphetamine. *J Urban Health* 2002;79:549–55.

## Letters to the Editor

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