Multidisciplinary care plans

Dear Editor

Nicholas Zwar and colleagues report on a study to assess the success of multidisciplinary care plans for patients with type 2 diabetes (*AFP* January/February 2007). The importance of this study is in its attempt to measure the impact on clinical outcomes as well as patterns of care.

As the authors note the chosen retrospective 'before after' study design is a weak design, which is justified on the basis that care planning was too entrenched. However, as 42% of GPs responding to the invitation to participate in the study were ineligible by virtue of not having conducted a care plan, a suitable control group was available. The failure to adoption a cluster RCT is hard to understand.

The authors present clinical results for all 230 study patients and separately for the 146 who receive multidisciplinary diabetes care. The authors report that for all 230 patients, care planning results in a small but statistically significant reduction in mean SBP, mean DBP and mean total cholesterol, but not HbA1c. But that for patients who also receive multidisciplinary care, the improvement in clinical outcomes is considerably greater and with significant improvement in mean HbA1c also observed. As a matter of logic, this means that for patients who received a care plan but not multidisciplinary care (n=84), their outcomes did not improve (and probably deteriorated).

This suggests an alternative interpretation of the study, that multidisciplinary care improves patient outcomes, which may be facilitated by care planning. While the authors report a large and significant increase in the number of diabetes related care professionals seen by patients, in the absence of a 'no care planning control group' it is not known how this compares with access to such services by patients not receiving care planning. The study results seem to suggest that the simple preparation of a multidisciplinary care plan does not improve clinical outcomes; rather it is the associated changes in clinical practice and access to pertinent diabetes specific health care professionals. This has at least two important policy implications: the need to ensure access to diabetes specific health professionals for referral; and the likely failure of the new GP only care planning 'chronic disease management' items 721 to 731.

It will be interesting to see what future studies of the GP only care planning items reveal in terms of effect on patient care and outcomes.

Leonie Segal, Chair Health Economics
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Reply

Dear Editor

We agree with Professor Segal that a controlled design would have provided a higher level of evidence. However we did not consider that a controlled design was possible given the general availability of care planning and therefore did not have the resources in our NHMRC grant to conduct such a study. The minority of GPs who had not adopted care plans are likely to be different in a range of practice characteristics from the earlier adopting majority so a cluster randomised trial in that group would be problematic even if the resources had been available.

We agree that there is a range of possible reasons for the improved care observed in the year following the care plan. It may be multidisciplinary nature care facilitated by the care plan, as suggested by Professor Segal, or it may be that the care was more systematic or a combination of both. It will indeed be important to examine whether the revised items (GP management plan and team care arrangements) result in improved care and patient outcomes. The lack of studies examining patient outcomes from these important reforms has been and remains a matter of concern.

Nicholas Zwar, Professor of General Practice
School of Public Health and Community Medicine
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General practice consultations

Dear Editor

The article 'General practice consultations – how well do doctors predict patient satisfaction?' (*AFP* March 2007) suggested 'that the doctors were not aware when patients desired a longer consultation'.

We think this is not supported by the data, but is actually the opposite. The data suggest that the patients are more satisfied on 'perceived time' than the doctors' prediction.

We acknowledge this component has the smallest difference in score among the four CSQ components. The correlation of these two items was also lowest among the four components of the CSQ. The low correlation suggests patients and doctors are more divergent on perceived time than the rest of the CSQ.

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Reply

Dear Editor

The three items in the Consultation Satisfaction Questionnaire perceived time scale all refer to the duration of the consultation: patients giving a low score on this scale are indicating a preference for a longer consultation. Our results showed that doctors were able to predict only 3% (ie. 0.18 squared) of the variance in patients' scores on this scale and were thus poor at detecting those patients who were dissatisfied with the length of the consultation.

Bianca Cannon, Tim Usherwood
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Bevacizumab on the PBS

Dear Editor

The article 'Age related macular degeneration' (*AFP* May 2007) includes the statement: 'Bevacizumab is Pharmaceutical Benefits Schedule (PBS) approved for use in patients with colorectal cancer'.

This is incorrect, unfortunately. Bevacizumab is not available on the PBS for the treatment of colorectal cancer. Roche are planning to submit an application to the PBAC. The timing of this application is not yet certain.

Avastin (bevacizumab) received TGA approval in February 2005 for the treatment of metastatic colorectal cancer. In the absence of funding via the PBS, Roche currently has set up the Avastin Access Program (AAP) for patients with metastatic colorectal cancer, which helps make bevacizumab treatment more available. Patients need to speak with their doctor to access this program.

David Kingston
Medical Director, Roche Products

Early detection of prostate cancer

Dear Editor

Madjar, Denham and Rashid are to be congratulated on their excellent paper exploring the role of women in the early detection of prostate cancer (*AFP* May 2007). The prognosis for many common cancers is strongly influenced by the mode and timing of presentation for treatment.[1] The health belief model predicts that one 'cue to action' for help seeking behaviour is the patient's perception that their symptoms are harbingers of a life threatening condition.[2] Thus the role of significant others in validating the decision to consult has a recognised theoretical basis. However one cannot assume that partners will offer appropriate advice. Awareness campaigns will be necessary and may not impact on those communities most likely to benefit. In a recent survey of women in the waiting rooms of doctors surgeries in Western Australia we were able to demonstrate that 75% of cases with colorectal symptoms identified as 'likely' or 'very likely' to have cancer had no 'red flag' features. Older sufferers with persistent rectal bleeding and or diarrhoea were not more likely to be advised to seek an urgent appointment. On the other hand 8 out of 10 of those who would be encouraged to make an urgent appointment by such 'lay advisors' could be reassured that their symptoms had a benign aetiology. Given that the majority of cancers are only diagnosed after the appearance of symptoms and not from screening programs, the strategy of empowering lay advisors to boost the prospect of early presentation is important.

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References

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Vitamin D deficiency

Dear Editor

I read with interest the article by Benson and Skull (*AFP* May 2007). It is true that in Australia high dose vitamin D supplements are not widely available for the treatment of adult vitamin D deficiency. The option however of using common low dose supplements to administer 500–1000 IU vitamin D per day is slow and conservative. A faster regimen is to prescribe 1000 IU supplements, three capsules, three times per day for 1 week and thereafter continue 1 capsule per day. There is large interindividual variation among adults in the amount of vitamin D required to correct deficiency. Serum 25OHD may be re-measured at 5 weeks (not 2–3 months) and the above regimen restarted if the deficiency persists.

Repletion of vitamin D should be accompanied by attention to calcium nutrition. If improved food selection cannot address this and calcium tablets are required, they should be taken away from food (eg. before retiring to bed). Their prescription with food is reserved for the setting of renal disease when they serve as phosphate binders. Plain calcium supplements are preferred to those with additional minerals. There are insufficient randomised data that these other minerals are clinically helpful and their potential interactions with skeletal drugs are not determined.

There is no indication to routinely measure serum PTH when assessing or managing adult vitamin D deficiency, especially as there is wide interindividual variation in serum PTH for any given level of serum 25OHD. While there may be deleterious skeletal and nonskeletal effects from secondary hyperparathyroidism, clinical trials have not yet used PTH as a management endpoint. Instead, they have tested a vitamin D dose or a targeted serum 25OHD level. The routine measurement of PTH in the setting of vitamin D deficiency remains in the research domain.

Bisphosphonates are used to treat osteoporosis. They are not indicated for pseudofractures of osteomalacia. Furthermore, clinical trials of bisphosphonates required participants achieve adequate vitamin D and calcium nutrition. The drugs antifracture efficacy is unproven unless these states are achieved.

Bone densitometry has no routine role during the repletion of adult vitamin D deficiency. If it is otherwise indicated, it may be delayed until the skeletal lesion of vitamin D deficiency is repaired in order to determine whether a coexisting low bone density, eg. from an osteoporosis, remains. This could then be investigated and managed as appropriate. It is worth remembering in this context that clinical trials of specific anti-osteoporosis drugs required low bone density as an entry criterion. Data in support of their antifracture efficacy in the absence of low bone density are limited.

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