Epilepsy in adults

Dear Editor

I found Dr Tan's article (*AFP* March 2014)[1] generally helpful, particularly the information about the newer agents that are now becoming more generally available. However, I believe his section on driving is a little misleading as it refers only to the standard for private vehicle licensing. The medical standard for driving commercial vehicles[2] and for driving other modes of public transport, such as trains,[3] is necessarily more restrictive, but this is not reflected in his article. Doctors who rely on this information when advising their truck driver patients may recommend a return to commercial driving when it is not permitted, or may inadvertently cause frustration, disappointment and disputation when such an individual is informed that they cannot return to their work.

I do not believe a lot more detail is required; a simple statement along the lines 'More stringent standards apply to commercial vehicle drivers and other professional drivers' would be sufficient to alert doctors to make further enquiries when advising their professional driver patients.

Keith Adam
Medibank Health Solutions Pty Ltd
Brisbane, QLD

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3. National Standard for Health Assessment of Rail Safety Workers 2013.

Reply

Dear Editor

Dr Adam is entirely correct in pointing out that different standards exist for commercial driving licenses, and that this has substantial vocational implications for some patients. I concur with his suggested addendum. Beyond this, there are other exceptional cases for which the required period of seizure freedom exceeds 6 months, and some instances in which the period of restriction is briefer, as outlined in Section 6.2 of the referenced guidelines,[1] pp. 75–86.

In all but the most straightforward cases, adjudication of fitness to drive is best left to the DLA rather than doctors. Particularly difficult cases should be referred to epilepsy specialists or specialists in occupational or forensic medicine.

Dr Meng Tan
Melbourne, VIC

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Approach to low back pain – chiropractic

Dear Editor

Thank you for the informative article about a chiropractic approach to the common presentation of mechanical low back pain (*AFP* January–February 2014).[1]

The authors refer to a set of guidelines published by Bussières et al[2] for use of diagnostic imaging in musculoskeletal complaints – I would be interested to know what their experience is with actual adherence to such guidelines.

Our common aim is appropriate and judicious use of diagnostic imaging for lower back pain. Anecdotal evidence might suggest an increased use of imaging referrals such as X-rays for lower back pain by chiropractors and medical practitioners alike because of patient expectation and other factors. I can see that this has been partially addressed by the Chiropractice Board (www.chiropracticboard.gov.au/Codes-guidelines/FAQ/Conduct-performance/Chiropractic-diagnostic-imaging.aspx); however it but might be worth expanding on it.

What is currently being practised? Are we, chiropractors and medical practitioners alike, requesting imaging too quickly? And if so, why?

It was encouraging to read the abstract by Lyons et al[3] on 'Perspectives of older adults on co-management of low back pain by doctors of chiropractic and family medicine physicians', which highlights patients' desire for better teamwork among health professionals.

Fabian Schwarz
Remote Health – NT Department of Health
Darwin, NT

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Dear Editor

We thank Dr Schwarz for his interest and his letter in response to our article on chiropractic care for low back pain.[1] We have been involved in a number of studies in Australia in primary care settings (general practice, physiotherapy and chiropractic) that have addressed the issue of imaging for the management of low back pain in primary care settings.

The uptake of clinical practice guidelines into clinical practice is a challenge facing all healthcare professions,[2] and this is no exception for primary care practitioners treating patients with low back pain. Despite clinical practice guidelines being clear about when to undertake imaging for patients with low back pain,[3,4] it seems that in many instances numerous factors influence whether the guidelines are followed. Some of these factors include patient

expectations of receiving an X-ray for low back pain,[5] concerns by practitioners about overlooking pathology and using imaging as a risk-minimisation strategy for fear of litigation.[6,7] Another factor that inhibits uptake of clinical practice guidelines is the lack of successful strategies required to disseminate the information. This has been highlighted in a recent study undertaken in Australia in general practice,[8] and for chiropractors and physiotherapists this is the subject of a randomised trial yet to report.[9]

Existing research indicates that Australian chiropractors' adherence to clinical practice guidelines with respect to undertaking X-rays is low,[10] but this also seems to be similar for Australian general practitioners.[11] One of the challenges would appear to lie in refocusing patient and practitioner expectations with respect to imaging for low back pain, as both patient and practitioner attitudes and beliefs seem to influence whether imaging is performed.[12] We agree with Dr Schwarz that improved inter-professional cooperation between general practitioners and chiropractors could assist in providing patients with the same messages to ensure that management of low back pain is consistent with published evidence-based practice guidelines.

Simon French, Queen's University, Ontario, Canada
Peter Werth, Carrum Downs Chiropractic Centre, Carrum Downs, VIC
Bruce Walker, Murdoch University, Perth, WA

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Letters to the Editor

Letters to the Editor can be submitted via:
Email: afp@racgp.org.au
Mail: The Editor, Australian Family Physician
100 Wellington Parade
East Melbourne VIC 3002 Australia