

## Transsexualism

### Dear Editor

Many thanks to Karen Gurney (*AFP* April 2010) for an interesting, informative and thought provoking article on transsexualism (TS).

While 'sex' in its biological sense may be easily determined at birth, 'gender', a product of congruence between genetics, gonads, genitals and the psyche is a more complex and fluid concept. Although TS was introduced to the medical community by Dr Harry Benjamin in the 1950s, it is hitherto an area fraught with a multitude of challenges both for the patient and the doctor.

Despite the most recent TS prevalence estimates of one in 12 000 males and one in 30 000 females in Western countries, management of this important condition happens in a relatively evidence free manner owing to the paucity of research and a lack of formal training in diagnosing and treating TS. There are no long term outcome studies of lifelong hormone replacement therapy in the gender reassigned or should I say, reaffirmed person. However, organisations such as World Professional Association of Transgender Health<sup>1</sup> have established 'standards of care' which may be useful for interested health practitioners. More locally, the 'Tranznation report' by the Melbourne based Centre in Sex, Health and Society<sup>2</sup> has some significant findings useful for the medical community.

It is important that there is timely recognition of people with gender issues, respectful engagement and effective management of this life transforming condition. General practitioners are well placed to provide the much needed care owing to the comprehensiveness and continuity of service provision.

Jay Ramanathan  
Sydney, NSW

### References

1. World Professional Association of Transgender Health. Available at [www.wpath.org](http://www.wpath.org).
2. Couch M, Pitts M, Mulcare H, Croy S, Mitchell A, Patel S. Tranznation: a report on the health and wellbeing of transgender people in Australia and New Zealand. Australian Research Centre in Sex, Health and Society, Melbourne. Available at [www.glhv.org.au/files/Tranznation\\_Report.pdf](http://www.glhv.org.au/files/Tranznation_Report.pdf).

## Slipped upper femoral epiphysis

### Dear Editor

The article 'Slipped upper femoral epiphysis in children'<sup>1</sup> (*AFP* March 2010) is a timely reminder of this condition.

I was disappointed however, to see that no mention was made of the important role of bone scanning in the diagnosis. It is true that X-ray changes may be subtle at an early stage. These rely on displacement having occurred. The pathophysiology underlying this condition is of a stress or occult fracture through the growth plate and this can be diagnosed on a bone scan before any displacement of the epiphyseal head. The typical bone scan features are of increased vascularity across the upper femoral growth plate on the blood pool images and increased uptake and widening of the growth plate on the delayed views. This is usually best seen with pinhole images and often with the hips in external rotation.

Diagnosing this condition with a bone scan before any displacement is evident on the plain radiographs allows for the best outcome. A negative X-ray does not exclude the diagnosis. It just excludes displacement of the epiphysis, although the underlying 'fracture' pathology may still be present. If present, this is the optimum time to make the diagnosis. In more complicated cases, the bone scan may also allow diagnosis of avascular necrosis of the femoral head or chondrolysis. If a slipped femoral epiphysis is not present, the bone scan may also aid in the diagnosis of alternate pathologies such as osteomyelitis, arthritis, transient synovitis, stress fractures or neoplasms.

I agree with the authors that the diagnosis of slipped femoral epiphysis should be considered in children with hip pain in this age group, especially in more obese children. However, should a radiograph be normal and the condition still considered possible, then a bone scan is the most sensitive way of detecting or excluding the condition early on. Early diagnosis before displacement allows early therapy and minimises complications.

Stephen Allwright  
Sydney, NSW

### Reference

1. Weigall P, Vladusic S, Torode I. Slipped upper femoral epiphysis in children – delays to diagnosis. *Aust Fam Physician* 2010;39:151–3.

### Reply

#### Dear Editor

I write this letter on behalf of my colleagues Prue Weigall and Sharon Vladusic in response to the letter from Dr Stephen Allwright. In the first instance, the study we performed, which has been published in *AFP*, was to highlight the delays in diagnosis of slipped capital femoral epiphysis and to try and ascertain why and where those delays occurred. The article was never intended to be an all encompassing paper on slipped capital epiphysis and particularly not intended to address the differential diagnosis of hip pain in the adolescent child.

A nuclear medicine bone scan certainly has a role in the diagnosis of hip pain where the diagnosis is not evident on more simple investigations. However, in our group of children, all of the children had displacement of the capital femoral epiphysis and therefore there was no need to consider a bone scan. A 'preslip' may have a truly normal X-ray in a child with hip pain, and a bone scan will probably have a role in the investigation. However, I disagree with the promulgation of the concept that a 'slipped' epiphysis can have a 'normal' radiograph or that a bone scan should be performed where the diagnosis is clear.

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Royal Children's Hospital  
Melbourne, Vic

## Nodular skin swelling

### Dear Editor

I would like to thank the authors of 'A patient with nodular skin swelling' (*AFP* April 2010)<sup>1</sup> for their article. However, I disagree with their conclusions.

The patient had a sizeable skin mass which was thought to be infective (abscess, carbuncle or infected cyst) and antibiotics were commenced. This was judged as 'appropriate

treatment'. It is basic medical knowledge that an infected collection of significant size requires drainage, as antibiotics alone are unable to lead to resolution of the purulent/necrotic material.<sup>2,3</sup>

The authors have also concluded that the skin tumour was a primary squamous cell carcinoma (SCC), probably on the basis that there is contiguity of the tumour with the overlying epidermis on histological examination. Contiguity with the epidermis is not unusual as a subcutaneous malignancy infiltrates the surrounding tissue. Also primary cutaneous SCC has a significant epidermal/dermal component such as thickening and keratosis.<sup>1</sup> A metastasis from an internal malignancy (as I believe is the case here) tends to have minimal epidermal/dermal involvement when compared to a relatively large infiltration of the subcutaneous tissue.<sup>1</sup>

Obviously, these points would not have changed the patient's prognosis, though they may affect the validity of the diagnosis.

Steven Tomas  
Dubbo, NSW

## References

1. Khajotia R, Raman S, Rajadurai P, Yaacob W. A patient with nodular skin swelling. *Aust Fam Physician* 2010;39:219–20.
2. Oxford Textbook of Surgery. Available at [www.ciap.health.nsw.gov.au](http://www.ciap.health.nsw.gov.au) [Accessed 12 April 2010].
3. eTG. Available at [www.ciap.health.nsw.gov.au](http://www.ciap.health.nsw.gov.au) [Accessed 12 April 2010].

## Reply

### Dear Editor

In reply to Dr Tomas, we would like to point out that it is not unusual that when a poorly controlled diabetic patient first comes to the GP with a skin swelling which appears to be infective in origin, the GP will prescribe a course of antibiotics, adjust his antidiabetic medications, and ask him to follow up in a few days. A GP will usually not resort to surgical intervention (such as incision and drainage) the first time a patient is seen, if an infective aetiology to the skin swelling is suspected. In the case we described, the patient defaulted on his follow up appointment. Had the patient followed up as advised and the lesion had not subsided in a few days in spite of antibiotics and good glycaemia control, the GP would have certainly then sought a surgical opinion for the lesion. It is also obvious that the GP could not have suspected a malignancy in

the first instance, as the lesion appeared to be infective in origin.

Dr Tomas then states that we concluded that the skin lesion was a primary SCC 'probably on the basis that there is contiguity of the tumour with the overlying epidermis on histological examination'. Dr Tomas' assumption is entirely erroneous, and nowhere in our article did we offer this finding as a basis for our conclusion. Indeed, we stated quite clearly (in the body of the text, and again in the legend describing Figure 3a) that the skin lesion was noted to be 'originating from the overlying epidermis with invasion into the underlying stroma'. Our conclusions were based on the fact that the major component of the carcinoma was in the epidermis and upper dermis, was associated with in situ change of the adjacent nonulcerated skin, and that there was minimal involvement of the deep dermis and subcutis. Our histological findings are therefore untenable with Dr Tomas' view that the skin lesion in our patient is a metastases. The histology is in sharp contrast to the features, which would be present in a SCC metastatic to the skin (where a significant deep dermal and/or subcutaneous malignant component not accompanied by in situ change of the overlying skin, would be the norm).

Rumi Khajotia, Malaysia  
Sree Raman, Malaysia  
Pathmanathan Rajadurai, Malaysia

## Early diagnosis of bipolar: SUSPICIOUS

### Dear Editor

One of the most frequent questions I am asked when lecturing to GPs is when to suspect that an episode of depression is likely to indicate undiagnosed bipolar illness, with the resultant need for a mood stabiliser. While the formal diagnosis of bipolar illness must await an episode of mania or hypomania (and I do suggest enquiring about nights of reduced need for sleep with no impairment of energy next day as a useful indicator of hypomania), I have recently developed the mnemonic SUSPICIOUS to summarise the current academic and clinical expert views indicating possible bipolar illness.

- S Severe
  - U Unusually heavy limbs (psychomotor retardation)
  - S Short duration
  - P Postnatal illness
  - I Intermittent/recurrent
  - C Crazy ideas (delusions, hallucinations)
  - I In the family
  - O Overeating/oversleeping
  - U Under 25 at first episode
  - S Swings of mood while depressed.
- For those wishing further information, I recommend the review article by Mitchell et al.<sup>1</sup> I hope your readers might find this information of use.

David Horgan  
Clinical Associate Professor of Psychiatry  
Kew, Vic

## Reference

1. Mitchell PB, Goodwin GM, Johnson GF, Hirschfeld RMA. Diagnostic guidelines for bipolar depression: a probabilistic approach. *Bipolar Disord* 2008;10:144–52.

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