Patients with dementia

Dear Editor

The article by Bridges-Webb et al (*AFP* November 2006) highlights the difficulty for busy GPs in managing a complicated problem such as dementia where the identification of cognitive impairment is just the start of a multidimensional assessment and management process. This involves a diagnosis of dementia rather than other causes of cognitive dysfunction and then the identification of the specific form of dementia. Then follows an assessment of comorbidities, clearly the responsibility of the GP, followed by functional and psychosocial assessments without which the problem cannot be adequately managed and carers supported. Moreover, many of these patients and their carers need case management throughout the 10 years or so of the illness to manage the innumerable behavioural and psychological problems.

These responsibilities can only be adequately discharged by a sharing arrangement between the GP and a community dementia nurse, either based in the practice or, more likely, in the local community aged care service or ACAT. Unfortunately, governments have been reluctant to accept responsibility for funding these nurses resulting in the situation in Australia where we spend $100 million per year on cholinesterase inhibiting drugs that benefit only a minority, but only $20 million on community dementia nurses, that would benefit almost everyone.

For those GPs lucky enough to have a local community dementia nurse, please try this wonderful resource and experience a new way of managing this demanding illness.

John Ward
Wallsend, NSW

Abortion and the law

Dear Editor

Dr Bird's article on abortion and the law in Australia (*AFP* November 2006) failed to mention that the South Australian Criminal Law Consolidation Act 1935 was amended in 1969 making SA the first state in Australia to clarify and liberalise abortion law.

An important clause of the amended act that Dr Bird did not mention is that for an abortion to be legal it must be performed in a prescribed hospital. This clause is going to present some medicolegal problems when RU486 (mifepristone) becomes generally available in Australia.

Dennis Chambers
Glen Osmond, SA

Dysmenorrhoea

Dear Editor

I was quite pleased when I opened my latest edition of *AFP* to see that the month's topic was pelvic pain (*AFP* November 2006), something I find quite interesting and challenging in general practice.

My pleasure was short lived to say the least. I am a 32 year old woman, and do not consider myself to be either behind the times, or prudish. I was however shocked when reading Dr Reddish's article on dysmenorrhoea. While I smiled at the reference to the television comedy 'We can be heroes', I was then amazed and dismayed to read the next line. Forgive me, but I think it was completely unnecessary to refer to the practice of oral sex with a menstruating women in an article about period pain. And while I admit to having my sensibilities slightly offended by the terms 'rainbow kiss' and 'dolmio grin', I was more annoyed that a peer reviewed medical journal of some esteem would feel the need to print such things.

I then read the passage aloud to my husband, who is a cardiologist. He laughed out loud and almost fell off his chair! I had a similar response from a female friend who suffers with significant dysmenorrhoea. She assured me she had never been questioned about oral sex practices during consultations regarding period pain, and as a consumer/patient, failed to see the requirement for it also.

I can certainly see the reason behind documenting lay terms for sexual practices, drug taking behaviours and the like, so that doctors will be able to interpret what their patients are saying. I cannot however, see why a professional medical publication needs to use the same language in the text of an article, where it is clearly irrelevant. Let us not take the practice of 'dumbing down' too far. I for one do not appreciate it.

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