ADDRESS LETTERS TO
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Vision at risk

Dear Editor

Our thanks go to *AFP* for the recent issue 'Vision at risk' (*AFP* October 2009). Numerous articles[1–4] highlighted the difficulties experienced by GPs in the assessment, investigation and management of potentially catastrophic acute eye presentations. Although the articles were excellent, we feel that they only covered those presentations from the 'severe' end of the clinical spectrum, and failed to address the issue concerning eye presentations that arise in every day general practice – what to do with an eye presentation where there is a degree of clinical uncertainty. In a recent article by Statham et al[5] 10/11 of the patients that suffered a severe adverse event due to incorrect primary health care provider (PHCP) diagnosis and treatment had presented with a unilateral red eye, with a mean delay in referral to a specialist service of almost 8 days.

Traditional teaching of PHCPs is to, 'Beware the unilateral red eye – think beyond bacterial or allergic conjunctivitis'[6] and to seek an appropriate ophthalmological opinion if symptoms fail to settle.[7] To make explicit the dangers associated with the care of acute eye disease by PHCPs, may we suggest a list of 'golden rules of acute eye presentations' to *AFP* readers:

- if there is any doubt in diagnosis or treatment, refer
- if the condition is not improving in 12–24 hours, refer
- if the patient reports eye (globe) pain, refer
- if there is a concerning change in vision, refer
- if the patient has only a single 'good eye' and develops symptoms in that eye, refer immediately
- any diagnosis that requires treatment with steroid drops requires ophthalmic advice/opinion before commencing treatment.[8]

We would be extremely interested in the opinion of other PHCPs, and in particular our specialist ophthalmologist colleagues, to the list of recommendations.

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Health promotion in Australian general practice

Dear Editor

We agree with Dr Achhra (*AFP* August 2009) that an important barrier to health promotion in Australia is the inconsistency of GP training in health promotion.[1] Dr Achhra lists five barriers to health promotion by GPs. Apparent barriers may reflect language used in health promotion that is different from that used by GPs, as much as attitude, time or understanding. Other barriers can be overcome by training and support.

Effective health promotion requires a mix of strategies, including clinical and individual level interventions, education and advocacy, community action and supportive environments.[2] Therefore, as GPs are the principal providers of primary health care in Australia, their involvement in health promotion is essential for integrated health promotion.[2] As outlined by Achhra, many GPs already provide health promotion interventions including immunisation, screening, individual risk assessment services and health education, but may not see them as health promotion.

However, training in health promotion theory and practice would improve GPs' understanding and involvement across the spectrum of health promotion interventions. This would ensure that health promotion is performed under a common framework and understanding, using the same language. It would also enhance GPs' understanding of others' roles and responsibilities, leading to better integration of services and more effective health promotion.[2]

There will be health benefits for the entire community from consistent training of GPs in health promotion. We would like to see GPs understand the central role of health promotion in improving population health and recognise that health is determined by social factors: early life experiences, education, employment and occupation, nutrition, substance use, social inclusion and social protection, health literacy,[3] and access to health care.[4]

Health promotion is the process of enabling people to increase control over, and to improve, their health. General practitioners have a role in this.

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Carpal tunnel syndrome

Dear Editor

The conclusion by Conolly and Mckessar[1] (*AFP* September 2009) that carpal tunnel syndrome (CTS) can be work related has been confirmed by other research. In a large cohort study, Violante et al[2] demonstrated increased risk of CTS with several medical conditions – mainly endocrine and connective tissue disorders – as well as with biomechanical overload at work. They confirmed the validity of the exposure standard developed by the American Conference of Government Industrial Hygienists. This is based on objective assessment of 'hand activity level' and peak force. This research is important for prevention, as it gives us valid guidelines for addressing those workplace factors which contribute to CTS.

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Carpal tunnel syndrome

Dear Editor

Conolly and McKessar[1] (*AFP* September 2009) rightly state that carpal tunnel syndrome (CTS) is a common constitutional condition and strongly associated with gender, age and obesity. They also note that the question of work relatedness must be considered on a case-by-case basis. They reviewed a large number of cross sectional studies purporting to show an association between work practices and CTS. Contrary opinions were also presented.

A considerable number of cross sectional studies are of poor quality and are limited by selection bias, diagnostic issues and the failure to account for personal characteristics, constitutional factors, concurrent medical conditions and nonwork related hand use. For example, in the study by Silverstein et al,[2] referred to by Conolly and McKessar, the diagnosis of CTS was based on history and examination alone. Nerve conduction studies were not performed!

We are, therefore, fortunate to have two well conducted longitudinal studies which avoid the pitfalls of cross sectional studies.[3–5] In these studies, the work exposure was categorised and the health effect, ie. CTS was defined and followed prospectively with annual nerve conduction studies for a minimum of 5 years. The authors of both of these studies concluded that work practices do not lead to an increased risk of CTS.

Therefore, given the best medical evidence available,[6] examiners can be quite confident in stating that CTS is not a work related condition in the vast majority of cases. Judgment is only needed in the occasional case of unilateral CTS where local factors may apply.

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