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Chronic heart failure management in Australia – Time for general practice centred models of care?

Dear Editor

As a general practitioner, I am immensely supportive of initiatives in developing capacity in general practice to manage chronic conditions, such as chronic heart failure (CHF). While emerging evidence for the success of GP-mediated care is highlighted by Scott and Jackson,¹ I believe we should be cautious in suggesting GP-mediated programs can achieve dramatic successes beyond these by the multidisciplinary disease management program for CHF (CHF-DMPs).

Studies quoted in the original article demonstrated some outcome improvements in GP-mediated programs. However, caution should apply in coming to conclusions juxtaposing these results with studies that failed to show outcome improvements in patients attending CHF-DMPs. The two sets of evidence were represented by studies with very heterogeneous methodology utilising dissimilar outcome measures. It is worth noting, even in a study quoted to favour GP-mediated programs, that there was 'no significant difference between the intervention and control groups for the combined end-point of death or hospital readmission';² the noted care improvements were in secondary outcomes. The authors' suggested feasible model of care, GP-mediated diabetic care,³ quoted improvements in surrogate rather than clinical outcomes.

While GP-led programs may address particular access issues (eg. in rural areas), and indeed evidence from comparable cardiovascular disease (CVD) prevention programs show participation in GP-based programs far exceed that of hospital-based programs,⁴ one must recall CHF is a very different chronic disease than, say, diabetes. Follow-up of the Hillingdon Heart Failure Study demonstrated CHF having a much higher and earlier morbidity and mortality from time of diagnosis compared to other chronic diseases.⁵

This natural history may explain the apparent failure of CHF-DMPs, and also have implications on GP-mediated care outcomes. Additionally, progressive improvement in CHF morbidity and mortality over the past decades is attributed to use of several classes of CHF medications. Evidence from comparative studies in 'real world' CVD prevention programs, however, suggests much less use of medications in GP than in hospital settings,⁴ and poorer target management in GP settings.⁶

It is for these reasons one should be pragmatically cautious before confidently suggesting GP-led programs can achieve successes beyond CHF-DMPs.

Dr Chee Koh, Sydney, NSW

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Reply

Dear Editor

We thank Dr Chee Koh for his thoughtful comments and agree we need to be cautious in recommending new models of care over existing ones that are strongly evidence-based. This was the rationale behind our tentative title

ending with a question mark. Moreover, we are not advocating a GP-led model of CHF-DMP, but one which has GPs with a special interest and enhanced skills working in close and flexible collaboration with cardiologists and the patient's usual GP. In the main, these patients are elderly and often have significant coexisting physical and social comorbidity, which requires the patient's GP team to be closely involved in parallel management. The studies we cite suggest superior or equivalent benefits from more GP-centred models of care that could overcome some of the barriers and limitations of traditional hospital-based, specialist-led CHF models of care that have been clearly identified in recent literature.

While we understand there are differences in prognosis and management between CHF and other chronic diseases such as diabetes, we contend that the principles underpinning our model of a GP beacon practice are applicable to the care of most, if not all, chronic diseases and deserve further evaluation in prospective trials that focus on patient-important clinical outcomes.

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Interactions between alcohol and prescription medications

Dear Editor

We thank Berends and Lubman for their excellent article on the delivery of alcohol and drug interventions.¹ The article highlights the importance of primary care strategies to detect risky drinking. We believe this should include primary care professionals assessing the possible concomitant use of alcohol and interacting prescription medications. This is important because patients may not voluntarily disclose their use of alcohol or interacting prescription medications in routine primary care consultations.

Up to 28% of older adults who consume alcohol also use sedative-hypnotics.² In a recent study, one in four Australian men aged 70 years and older who used sedative-hypnotics also consumed more than two alcoholic drinks daily.³ Pharmacodynamic interactions between alcohol and psychotropic medications may result in increased central nervous system depression.⁴ Chronic heavy drinking may induce liver enzymes responsible for drug metabolism. Additionally, alcohol is implicated in up to one-fifth of unintentional fatal prescription medication overdoses.⁵ Implementing strategies to promote awareness and detection of interactions between alcohol and prescription medications is likely to fulfil an important primary care need.

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Associate Professor J Simon Bell,
Melbourne, VIC

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Reply

Dear Editor

We thank Ilomäki and Bell for their important comments on our recent paper relating to the delivery of alcohol and drug interventions within primary care.¹ The risk of harm from combining alcohol with a number of commonly prescribed medications is an important issue for older people. With 10% of people aged 65 years or older drinking at levels associated with short-term harm, and more than one-third taking at least four medications concomitantly,^{2,3} it is critical that clinicians routinely screen for risky substance use.⁴ However, available evidence

suggests that practitioners typically prioritise other health issues and there is limited time to explore alcohol and pharmaceutical drug misuse within a standard consultation.⁴

While older people are high-end users of the health system, they do not usually present to specialist alcohol and other drug services. This means that enhanced screening and assessment practice within primary care is imperative.⁴ The use of collaborative care models, delivered within such settings, will improve older people's access to appropriate interventions.¹ Medicare Locals are well placed to facilitate this approach; an important development given Australia's ageing population.

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Hot water immersion for bluebottle stings

Dear Editor,

Thank you for the article on the use of hot water immersion for bluebottle (*Physalia* spp) stings (*AFP* June 2013).¹ Marine stings are an area of particular interest in which I have done research and I feel that there is some additional information that may be of use to readers.

The study by Loten et al² referenced in the article used hot water at 45°C for 20 minutes. Lower temperatures have not been demonstrated to be effective. Clearly there are challenges in obtaining and maintaining water at that temperature in a beach environment. It is important to measure the temperature of the water used for showering or immersion. While the article mentioned that there has only been one reported case of a thermal burn, it has been my experience that many people find it very painful, particularly at first, and are unable to tolerate such temperatures.

While heat at the correct temperature is most effective, it is worth remembering that cold is effective and, in the circumstances you are in, may be more accessible or more tolerable for the patient.

It is perhaps also worth considering that while the article refers to bluebottles, which are the more common single-tentacled variety of *Physalia* spp,³ there is a multi-tentacled species (illustrated in the article) that is less common and usually not identified but, as can be anticipated, causes a more severe sting and may include systemic symptoms including back pain, nausea and 'a feeling of being unwell'.

Another practical point relates to the removal of any tentacles that remain stuck to the skin. After removal, the article recommends washing with seawater because freshwater can cause the discharge of any remaining nematocysts on the skin. Therefore, washing with seawater is critical before any immersion in hot water.

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Letters to the Editor

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