

ADDRESS LETTERS TO

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Internet search engines

Dear Editor

Using www.yahoo.com in an attempt to quickly find accurate clinical information as endorsed by Dr Qureshi¹ (*AFP* July 2007) is not an example to emulate but rather a cautionary tale of how NOT to conduct a clinical search on the internet.

While Dr Qureshi concedes that a well built clinical question using the PICO model is essential, it is a shame that this approach was not modelled in the practice tip as this would have better guided the internet search.

PubMed Clinical Queries is a more appropriate internet based resource in which to search. Here the busy clinician could search by clinical study type and put, for example, 'venous thromboembolism d-dimer recurrence' in the search box and check off the box for 'diagnosis'. They could then choose to either conduct a 'narrow, specific search' or a 'broad, sensitive search'. I conducted this search as broad/sensitive and obtained 32 results that included relevant citations that were more recent than the 2003 *JAMA* article found by Dr Qureshi.

Dr Qureshi suggests that the use of yahoo.com is in the best interest of the patient because familiarity with the search engine allows the patient to become more involved with their care, and because such a search provides information in a form more easily understood by them. This attitude underestimates the patient and does them a disservice. If consumer health information is what one is after then the patient can be directed to a reputable resource such as MedlinePlus. Otherwise, it is in the best interest of the patient for clinicians to search online resources more suited to finding the best available evidence.

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Death after failure to diagnose Addison disease

Dear Editor

The article by Sara Bird¹ (*AFP* October 2007) highlights the importance of considering the diagnosis of Addison disease in patients with a chronic illness characterised by marked weight loss and severe fatigue.

Addison disease is a rare disorder, however, a history of chronic fatigue and lethargy, weight loss and increased skin pigmentation is typical. Other features are: anorexia and nausea, diarrhoea and abdominal pain, dizziness associated with postural hypotension, hypoglycaemia and hypercalcaemia (rare), and hyperpigmentation of mucous membranes of mouth and hard palate.

The definitive diagnostic test is a short synacthen test (response of serum cortisol to synthetic ACTH). Sixty minutes after 250 µg

tetracosactrin, the serum cortisol should be >550 nmol/L. In addition, serum sodium and cortisol levels may be low, serum potassium levels may be high, but these changes are not invariable findings in Addison disease and cannot replace a short synacthen test.

This case report highlighted: failure to recognise a seriously ill young patient; and failure to admit the patient to hospital and seek a specialist opinion regarding diagnosis and treatment.

The diagnosis was a difficult one, and clearly outside the experience of the junior doctors involved in the case. Nevertheless, severe fatigue, lethargy and weight loss should be recognised as potential symptoms of either Addison disease or hypopituitarism. The differential diagnoses of chronic fatigue syndrome, glandular fever and depression should be diagnoses of exclusion in such a seriously ill patient. The latter seems to have been clinically excluded in this case. Other diagnoses should only be considered after a normal short synacthen test.

Endocrine Society of Australia Position Statement

'Addison's disease should be considered as a differential diagnosis in any patient presenting with extreme fatigue, lethargy and weight loss. The diagnostic test is a short synacthen test'.

Peter R Ebeling on behalf of The Endocrine Society of Australia

Reference

1. Bird S. Failure to diagnose: Addison disease. *Aust Fam Physician* 2007;36:859-61.

Palliative care

Dear Editor

As a medical oncologist who through necessity and choice conducts palliative care, I was impressed with the model outlined by Shelby-James et al¹ (*AFP* November 2007). However, the issues discussed need some elaboration, particularly the paucity of 'spiritual concerns'. Clearly there will be overlap with other items (psychological, social and perhaps 'other') but often spiritual difficulties are not specifically sought and thus ignored. These issues may or may not be 'religious' (organised) but are generally existential and ontological (as death approaches). Limited research and my own experience indicate a major unmet need for open, sensitive and compassionate discussion of the spiritual dimension. Modern palliative care focuses on excellent physical symptom control but generally does not confront this eternal dilemma. Organised religions make a variable and uncertain contribution and seem less conspicuous around public hospitals, hospices and palliative care units.

To approach death without some spiritual angst seems unlikely and palliative care must openly address this issue.

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Carnett sign

Dear Editor

Abdominal tenderness on palpation is a common physical sign. If the tenderness persists when the abdominal muscles are tensed (Carnett sign positive) then the pain is unlikely to be due to intra-abdominal problems. Some other cause should be sought.

In their article 'Back, chest and abdominal pain – is it spinal referred pain?' (*AFP* June 2007), Harding and Yelland showed that the sign of abdominal tenderness conveys a wealth of information.¹ We can learn much by localising the source of the tenderness to an anatomical layer.² Carnett sign, named after the American physician who described it in 1926–1927, can assist.³ To elicit the sign the patient lies supine. If there is abdominal tenderness to palpation with the abdominal muscles relaxed, then the palpation is repeated with the muscles tensed by straight leg raising. If the pain is the same or worse with tensed muscles, then the sign is positive and the pain is likely to be coming from the muscles or other superficial structures and not from within the abdomen.

One surgical paper showed that only 6% of patients with significant intra-abdominal disease had abdominal wall tenderness (Carnett positive) but 28% of patients with nonspecific abdominal pain (NSAP) were Carnett positive.⁴ The authors did not look for the causes of NSAP, but in general practice this must be done. As always, a physical sign does not stand alone. A history suggestive of bowel pathology (anorexia, vomiting) and other signs such as fever or raised pulse rate may combine to point toward intra-abdominal causes (eg. appendicitis) even when Carnett sign is positive.

Carnett sign can help to diagnose recurrent abdominal pain in children. Up to 30% of children visit their doctor for repeated bouts of abdominal pain.⁴ In 1958, Apley defined recurrent abdominal pain as three or more bouts of pain extending over at least 3 months and causing changes in activity.⁵ Seventy to ninety percent of these children have nonorganic problems, but many have expensive and invasive tests to exclude serious pathology. Such pathology is unlikely if the pain is peri-umbilical, occurs only during waking hours, and there is no abdominal pain on palpation. Most children are nervous when we place them on a couch in a strange room and prod their abdomens with cold hands. Many complain of discomfort and/or pain. If a child is Carnett positive, then the abdominal pain is most likely to come from the muscles rather than an intra-abdominal organ.

In some of these children, the pain and tenderness in the tensed abdominal wall is so marked that it suggests chronic stress/tension in the abdominal muscles.⁶ Up to 90% also have headaches, often associated with occipital tenderness. Many also have reduced pain thresholds.⁷ In such children, a positive Carnett sign not only makes intra-abdominal pathology unlikely, but points toward anxiety/stress affecting muscles as a factor in their recurrent abdominal pain.

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