

Clubbing should not be attributed to COPD

Dear Editor

Chronic obstructive pulmonary disease (COPD) is still being erroneously reported in some journals as a cause of digital clubbing. COPD is a term that encompasses chronic bronchitis and emphysema and is defined by the World Health Organization as 'a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible'.¹

In 2004, an *American Family Physician* journal article included COPD in a list of causes of clubbing.² This statement was unreferenced. When contacted recently about this error, the journal defended the article, noting that several recent reviews supported the association between clubbing and COPD even in the absence of lung cancer. However, they cited only one review, a 2012 *American Family Physician* article, which repeated the unreferenced claim that clubbing is associated with COPD.³ The journal did not respond to a request for the other review articles used in its decision to take no action to correct this error.

Well-respected medical textbooks explicitly state that clubbing is not associated with COPD. This is supported by other literature, such as a 2005 review that cited 83 papers and did not identify COPD as a cause of clubbing.⁴ A search of PubMed for potential supporting evidence of COPD as a cause of clubbing reveals only an article from 1964.⁵ General practitioners must not be misled by these mixed messages as there is no evidence that COPD causes clubbing. Incorrect information on the causes of clubbing is potentially dangerous to patients. Clubbing in the context of COPD should prompt further investigation into respiratory causes of clubbing, such as bronchogenic carcinoma, interstitial pulmonary fibrosis or chronic lung infections including bronchiectasis, lung abscess or emphysema.

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References

1. World Health Organization. COPD: Definition, 2013. Available at www.who.int/respiratory/copd/definition/en/ [Accessed 8 December 2013].
2. Fawcett RS, Linford S, Stulberg DL. Nail abnormalities: clues to systemic disease. *Am Fam Physician* 2004;69:1417–24.

3. Tully AS, Traves KP, Studdiford JS. Evaluation of nail abnormalities. *Am Fam Physician* 2012;85:779–87.
4. Spicknall KE, Zirwas MJ, English JC 3rd. Clubbing: an update on diagnosis, differential diagnosis, pathophysiology, and clinical relevance. *J Am Acad Dermatol* 2005;52:1020–28.
5. Pain MC. Digital clubbing in chronic obstructive lung disease. *Australas Ann Med* 1964;13:167–69.

Metabolic syndrome

Dear Editor

I refer to Dr Harris's recent article on the metabolic syndrome (*AFP* August 2013)¹ and I agree that this collection of risk factors remains under-diagnosed in the community, despite its association with increased morbidity and mortality in cardiovascular disease and diabetes. I also think it is important to increase awareness of particular high-risk groups – as a psychiatry registrar I frequently see patients develop metabolic syndrome as a complication of their medication. This is predominantly with the use of atypical antipsychotics, which are recommended as first-line treatment for various psychotic disorders, including schizophrenia and, increasingly, mania. A recent study of the prevalence of metabolic syndrome in patients with schizophrenia in South Korea found a mean prevalence of 40.1%, according to International Diabetes Federation criteria.² There are also numerous studies that have associated schizophrenia with significant morbidity and mortality.³

Optimal management of this disorder requires increased awareness and education of patients and health professionals. Within our local mental health district there is a growing focus on routine measurement of fasting glucose, lipids and cholesterol, as well as measurement of waist circumference and BMI. A 'metabolic clinic' has also started within our service, which is operated by a general practitioner. This has proven to be effective in monitoring and managing metabolic syndrome within this high-risk group of patients.

Due to the nature of schizophrenia, some patients will be required to stay on their medication for a significant period of time, if not for life. Additional contributing factors to the development of metabolic syndrome in patients with chronic mental illness include the existence of comorbid depression or negative symptoms of schizophrenia resulting in

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reduced motivation to exercise and improve lifestyle choices. There is also a much higher prevalence of cigarette use in this patient group.⁴ Therefore, establishing a good interface between inpatient, community psychiatry and general practice is important. Perhaps this can be improved by the introduction of further metabolic clinics, increasing access to dietitians, or GP liaison psychiatry.

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References

1. Harris MF. The metabolic syndrome. *Aust Fam Physician* 2013;42:524–25.
2. Ko YK, Soh MA, Kang SH, Lee JI. The prevalence of metabolic syndrome in schizophrenic patients using antipsychotics. *Clin Psychopharmacol Neurosci* 2013;11:80–8.
3. Casey DA. Schizophrenia: medical illness, mortality and aging. *Int J Psychiatry Med* 2011;41:245–51.
4. Jiang J. Investigation of Cigarette Smoking among male schizophrenia patients, Institute of Mental Health/ Woodbridge Hospital, Singapore, August 2013.

Letters to the Editor

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Erratum

Bonney A, Albert G, Hudson JN, Knight-Billington P. Factors affecting medical students' sense of belonging in a longitudinal integrated clerkship. *Aust Family Physician* 2014;43:53–57.

Due to a production error, there was a misprint in the 'Methods' section of this article. The second wave of invitations for the study in November 2011 occurred 5 months into the clerkship, not 15 months. The correction has been made to the HTML version of this article.

Marquardt T. Managing skin infections in Aboriginal and Torres Strait Islander children. *Aust Family Physician* 2014;43:16–19.

Due to a production error, Table 1 contains two errors in the 'Organism' column. The first reference to Herpes simplex infection should be classified as 'Viral', not 'Parasite'. The first fungal infection should read 'Tinea', not 'Herpes simplex'. The table has been corrected in the HTML version of this article.

We apologise for these errors and any confusion this may have caused our readers.