ADDRESS LETTERS TO
The Editor, Australian Family Physician
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Yellow fever vaccination and HIV

Dear Editor

I read the article on HIV management[1] (*AFP* August 2009) with interest. I am a GP and have been working in travel medicine for part of my working week for nearly 10 years.

I was particularly interested in the advice regarding yellow fever. I note the advice to not vaccinate is keeping with Centers for Disease Control (CDC) guidelines, and is also backed up by the current 9th edition of the Australian Immunisation Handbook.

Yellow fever, on the other hand is a potentially fatal infection, and HIV infected individuals have been safely vaccinated against this disease. In their 'Manual of Travel Medicine', Yung, Ruff, Torresi, et al state: 'Symptomatic HIV infected individuals or those with a CD4 count <200 ...should be strongly advised against going to areas of intense yellow fever transmission. Asymptomatic HIV infected persons with a CD4 count >200 who must travel to areas where yellow fever risk is high should be vaccinated. In this population no increased incidence of adverse effects has been noted, and the vaccine appears effective. However, the vaccine should only be given for the traveller's protection. If the vaccine is only for legal purposes, a letter of exemption from the doctor is generally acceptable (this does not need to state the reason for the exemption)'.

This opinion has been echoed by other infectious disease specialists in Perth when the topic has come up for discussion, and on at least one recent occasion I have gone ahead and vaccinated an HIV patient on the basis of this.

As yellow fever can only be provided by a licensed centre, perhaps it may be more appropriate to note that while not generally recommended, yellow fever vaccine can in some circumstances be appropriate. Otherwise there is a risk that GPs not well versed with yellow fever issues may advise their HIV infected patients that yellow fever vaccine is not an option, despite the fact that the patient may intend to go to a high risk yellow fever zone regardless. As is always the case in travel medicine, it comes down to a discussion of relative risk.

I've also checked the 2008 WHO International Travel and Health Guide, which also states: 'In many industrialised countries, yellow fever vaccine is administered to people with symptomatic [sic] HIV infection or other immunodeficiency diseases, provided their CD4 count is greater than 200 and if they plan to visit areas where epidemic or endemic yellow fever actually occurs'.[2]

Aidan Perse
The Travel Doctor, Fremantle, WA

References

1. Denholm JT, Yong MK, Elliott JH. Long term management of people with HIV. Aust Fam Physician 2009;38:574–7.
2. WHO. International Travel and Health Guide. 2008; p.139.

Dementia – who cares?

Dear Editor

The money and time spent on the article 'Dementia – who cares?' (*AFP* August 2009)[1] should be spent on finding the aetiology of dementia. Meaningless statistics are no help.

Saying early diagnosis is important does not make much sense as there is no treatment. Stating that diagnosis needs special knowledge is nonsense. Any lay person who lives with the patient can recognise dementia. One has to think back to peptic ulcer and all the nonsense about what was causing it. Blaming unnecessary worry, wrong food, alcohol, and cigarettes, and then it turned out that it is an infection with *Helicobacter pylori* and can be cured with the right antibiotics.

Not all elderly people have dementia; it is quite possible that it is caused by some organism. Research should be directed in this direction.

Michael Kennedy
Sydney, NSW

Reference

1. Millard F, Baune B. Dementia – who cares? A comparison of community needs and primary care services. Aust Fam Physician 2009;38:642–9.

Reply

Dear Editor

Thank you to Dr Michael Kennedy for your letter regarding my recent article. Although there are costs involved in publishing a paper, as a general practitioner, I was pleased to supply my time to collect data that reflects the patient experience and present it in a paper that may alert health professionals to the need to identify and support dementia patients. Current 'accelerated research' is establishing evidence of the numerous aetiological factors that may contribute to dementia including over 500 gene candidates,[1] but this work is outside the scope of general practice. Evidence for the benefits of treatment is also accumulating,[2] but best outcomes are frequently obtained when started early in the disease, or even before the disease is noticed,[3] hence one of the many reasons for early diagnosis. Perhaps we should be promoting preventative strategies.[4] This is part of my current research, testing ways of getting the message out to both health professionals and the community.

Thank you for your interest and I hope we do find a solution before we all get too old to benefit.

Fiona Millard
Townsville, Qld

References

1. Bertram L, Tanzi RE. Thirty years of Alzheimer's disease genetics: The implications of systematic meta-analyses. Nat Rev Neurosci 2008;9:768–78.
2. Muller-Spahn F, Sollberger D, Wollmer MA. Antidementia drugs. Ther Umsch 2009;66:432–40.

3. Scarmeas N, Luchsinger JA, Schupf N, et al. Physical activity, diet, and risk of Alzheimer disease. JAMA 2009;302:627–37.
4. Shineman DW, Fillit HM. Novel strategies for the prevention of dementia from Alzheimer's disease. Dialogues Clin Neurosci 2009;11:129–34.

Health promotion in Australian general practice

Dear Editor

It was good to see an article on health promotion in general practice (*AFP* August 2009).[1] The author reports some gaps in GP training, especially at medical student and continuing medical education levels. The author's case might have been more compelling, however, had he actually consulted the RACGP Curriculum for General Practice.

The RACGP curriculum includes an extensive statement on population health and public health, with specific learning objectives on health promotion across the GP's professional life from medical student through to continuing professional development. The curriculum is freely available at www.racgp.org.au/curriculum.

Admittedly, a curriculum means nothing until it transfers from paper to practice, but the RACGP curriculum does provide clear direction for GPs seeking to gain skills in promoting the health of individuals and populations.

Steve Trumble
Chair, RACGP Curriculum Committee

Reference

1. Achhra A. Health promotion in Australian general practice – A gap in GP training. Aust Fam Physician 2009;38:605–8.

Should letters to the editor be evidence based?

Dear Editor

What is a 'letter to the editor' in *AFP*? Perhaps, following your recent rejection of my letter, formal international and scientifically established guidelines are required for publication.

The incredible knowledge of GPs isn't gathered, as most never write nor deliver appropriate papers in professional forums. Anecdotal stories abound, for example from the 1970s: psoriasis and hypercholesterolaemia links, SIDS and never place an infant face down, tight pants and hydrocoeles, pawpaw treatment for severe leg ulcers, and a melanoma 'epidemic'.

There is a huge unwritten library out there among your readers that if 'told' now, would be unacceptable, yet may become 'proven' one day. Some 'stories' are now evidence based, others just remain anecdotal.

Surely it is just such experiences your 'letters' section should encourage. It may lead to development of papers that satisfy your guidelines and meet the approval of even your most critical commentators.

Wisdom comes from experience and experience always starts with a case study of one! Does wisdom equal evidence based medicine?

Thomas Wenkart
Killara, NSW

Reply

Dear Dr Wenkart

While wisdom does not equate with evidence based medicine, and 'anecdotal evidence' is frequently dismissed as the bottom of the research food chain, clinical discoveries and impressions formed from clinical experience may often form the seed of a research question. In correspondence from another reader of *AFP*, I was alerted to an editorial on this issue in 2008 by Ian McWhinney, of A Textbook of Family Medicine fame. McWhinney posed the question: 'Is there a place for clinicians' observations, hunches, and insights in family medicine and general practice journals?'[1] His view was that there was a potential value in publishing these insights from clinicians, but demonstrated that they do not fit neatly into any current research or publication category. As editors and reviewers, therefore, we do not have criteria for judging their value or rigor. McWhinney suggested the following potential criteria:

- plausibility
- support from basic sciences
- clarity of the concepts, and
- reproducibility of the procedures.

Australian Family Physician cannot publish all letters it receives because of space considerations and so, inevitably, difficult decisions on which to include and which to exclude are made. McWhinney's criteria could form a useful addition to this decision making process.

Jenni Parsons
Editor in Chief, Australian Family Physician

Reference

1. McWhinney I. Assessing clinical discoveries. Ann Fam Med 2008;6:3–5.