A general practitioner and proud of it

I disagree with Tim Kenealy.[1] I am a general practitioner and proud of it. The emphasis on 'general' is important as I believe that 'generalism' is on the rise. We are more involved in medical education, we are rightly taking more responsibility for the management of many conditions, because in many instances we can do it better. This is being recognised by the increased funding into primary care. We are different from our specialist colleagues. They have used the strategy of becoming partialists to cope with the vast amount of medical knowledge there is to know. This is a great strategy for solving some problems, usually the more simple 'biomedical' problems. It fails abysmally when a holistic approach is needed. Most of my diabetic patients who have poor control have poor control not because of the technical management of their diabetes but because diabetic control is not high enough on their priority list. Only a generalist who is interested in all their problems has any chance of influencing this. I would suggest that if we want to change names then, as Campbell Murdoch did at the Wellington Conference on *Complexity*, we should refer to our specialist colleagues as partialists. Our strength is the difference in approach from the partialists. I do not want to join them; I want to remain a generalist.

Ben Gray, GP

References

[1] Kenealy T. GPs – Do we need to change our name? NZFP 2006; 33:86.

Sudden death from a ruptured cerebral artery aneurysm

In April 2004 you published a Coroner's Column regarding a 39-year-old man who died of a ruptured berry aneurysm, and commented that *'in anyone presenting with a sudden onset of severe headache the possibility of an intracerebral bleed needs to be kept in mind.'*

In order to further keep it in your readership's minds I inform you that I have dealt with the sudden death from a ruptured cerebral artery aneurysm of a woman in her thirties. She suffered from migraine headaches, but she reported that the headache prior to her death was unlike any migrainous headache she had ever had and was 'thunderclap' in nature.

Murray Jamieson
Coroner at Auckland

Evaluation of procedural skills in family medicine training

'Procedures are regarded as an integral part of family medicine. There are many advantages to doing procedures in the office: patients are more satisfied if procedures are done by their family physicians; physicians are able to provide continuity of care; procedures cost less than they would if performed by specialists; wait times are shorter; and physician satisfaction is greater. Studies show that family physicians are more likely to perform procedures in their practices if they received training for those procedures during residency.'

Rivet C, Wetmore S. Editorial. Cam Fam Physician http://www.cfpc.ca/cfp/2006/May/vol52-may-editorials-1.asp Accessed 18 Jul 2006.

HBOT in the treatment of pressure and leg ulcers

The June edition had many articles which were an interesting and informative read but there were two in particular which caught my attention because of my particular nursing speciality and because they relate so closely to my present work in a hyperbaric unit.

These two eloquently written and very informative articles were entitled *'Managing leg ulcers – it's not rocket science'* (NZFP 2006; 33:197–201) and also *'Hidden under the covers: Pressure ulcers in primary care'* (NZFP 2006; 33:192–196).

These both featured patient groups that we commonly treat with hyperbaric oxygen treatment (HBOT) yet very little mention was made in one article and the other did not mention our modality at all. We have found that HBOT is an extremely successful adjunctive treatment for problem wounds – both leg ulcers and pressure ulcers fall into this category.

One paper mentioned HBOT along with several other modalities, stating that there was a lack of evidence-based research for these and that the modalities needed to be considered with caution. Although the evidence for HBOT is less than for other modalities (the treatment is very hard to randomise and double blind due to its very nature), it is continually being added to and it isn't correct to state there is a lack of evidence for this modality. A good website to view is: www.hboevidence.com. This is a database of all randomised controlled trials in hyperbaric medicine in critical appraisal form.

There are, of course, patients who will not benefit from hyperbaric treatment or who have contraindications for treatment. All referrals to our Clinic are assessed by a physician and me to determine whether or not they might benefit from the treatment; we by no means need to be considered with caution!

The other paper that did not mention HBOT at all was from an area in New Zealand where there is not easy access to HBOT so it is understandable that HBOT was not considered in the range of treatments discussed, but I would like to highlight that if any GP has patients with chronic wound issues then HBOT should be considered despite the geographical area. We are situated in Auckland and have treated patients as far south as Taranaki, as far east as Tauranga and as far north as Whangarei. Christchurch hospital also has a hyperbaric unit.

We are governed by the Underwater Hyperbaric Medical Society (UHMS) and will only treat the twelve conditions that have evidence-based research supporting them: Air gas emboli, carbon monoxide poisoning, clostridial myonecrosis, crush injuries, decompression sickness, problem wounds, exceptional anaemia, necrotising soft tissue infections, refractory osteomyelitis, radiation tissue damage, compromised grafts and flaps and thermal burns.

Funding is provided by various sources including ACC, some DHBs and ING insurance.

Please feel free to contact me should you want more information regarding our unit or HBOT.

Referrals can be made on-line via our website: www.hbot.co.nz

Helen Polley
Wound & Hyperbaric Nurse
The Oxygen Therapy Clinic
Email: hpolley@hbot.co.nz
Tel: (09) 919 2340

Strep throat

'Group A ß-hemolytic streptococcal (GABHS) pharyngitis is one of the most common infections of children. For five decades, penicillin has been the treatment of choice for this infection, and it is currently recommended by the American Academy of Pediatrics, the American Heart Association, the World Health Organization, and the Infectious Diseases Society of America. Amoxicillin is often utilized in young children in place of penicillin V because of taste considerations. Although the problem of increasing antimicrobial resistance among bacteria is one of the most important infectious disease issues of our time, GABHS remarkably have never developed resistance to any of the penicillins or cephalosporins or shown any increase in penicillin minimal inhibitory concentrations over at least five decades.'

Shulman ST, Gerber MA. So what's wrong with penicillin for strep throat? Pediatrics. 2004;113:1816-1819.