Practical Solutions

I am a Northland GP and dairy farmer's wife; currently on maternity leave, I have clearly allowed my mind to wander while feeding the baby and the calves, yes, sometimes at the same time! Just prior to your recent article[1] I was thinking about the GP specific 'practical solutions' that are not taught formally. I would like to contribute the following that I have used:

Pyjama query

'What time do you get out of your pyjamas?' A simple one-question tool to use to monitor the impact of low mood on daily function of women with possible mood problems. Encouraging the patient to aim for an earlier 'get out of pyjamas time' can be a useful behavioural strategy. This may sound a little silly, but it does help the consultation and the patient's insight.

Male mortality syndrome

I see this in middle aged New Zealand men who previously rarely attended the practice, presenting on repeat occasions for seemingly minor symptoms with disproportionate concern. Upon questioning, there is usually an associated event, e.g. sudden death of similar aged friend, awareness of peers (especially other golfers) experiencing medical illness, difficulty with achieving activity (including fighting and sexual activity) or sporting expectations. It seems to be based around the acute realisation that they are not 'six foot tall and bullet proof' and the impact of that on their lives. Discussing this concept with the patient leads to fascinating conversation and insight about being a man and their health concerns and seems to sort out the presenting complaint too. Also to be considered in middle aged males contemplating marriage breakup for a younger woman or participating in an iron man for the first time.

Teachers' disease

Acute illness, usually flu-like or respiratory tract symptoms often protracted, in a patient who has recently been quite stressed or busy. The onset of the illness occurs after the pressure has come off, i.e. when on holiday. A discussion about the precipitating pressure and management of this is more therapeutic than specific treatment for the illness.

Vet–Med delusions of grandeur

Some days believing I am a vet and the next day wishing I was.

Yours in the spirit of #8 wire
Dr Tanya Quin

References

1. Editorial NZFP 2006; 33(4):230.

Needle length for infant immunisation

I notice that the POEM in the February 2006 edition of *NZFP* contains some incorrect information. The World Health Organization recommends a 25mm (not 16mm as stated) needle length for infant immunisations (World Health Organization. Immunization in practice: module 6 holding an immunisation session. WHO/IVB04.06).

A 25mm needle is the most commonly used needle length for IM injection in the antero lateral thigh/vastus lateralis muscle (NZ Immunisation Handbook Feb 2006 p89) with a 16mm used rarely for low birth weight babies and in the deltoid muscle of younger or thinner children.

Also in the USA a 90 degree angle is recommended for intramuscular injection. They have two techniques – a bunching technique requiring a 25mm needle and a stretching technique where a 16mm needle length may be adequate in the deltoid or thigh of young infants (p97 Plotkin and Orenstein Vaccines Fourth ed 2004 Elsevier inc and references 28-31 on p117). I think Dr Cooke was mistaken in stating the recommendation in the USA is a 45 degree angle for intramuscular injection.

Research in the *BMJ* published on 4 August 2006 by Linda Diggle also discusses this subject, *Effect of needle size on immunogenicity and reactogenicity of vaccines in infants: randomised controlled trial* (citation BMJ, doi:10.1136/bmj.38906.704549.7C).

Barbara Warren
Immunisation Coordinator, Otago