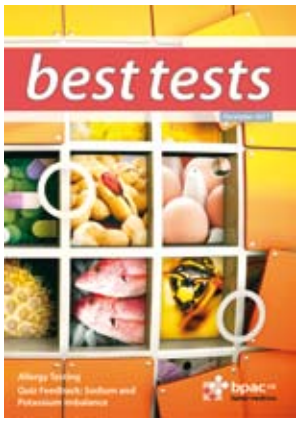

Use of the term "screening"

Dear Editor,
I opened the latest Best Practice Journal (Feb, 2012) and read the article about HbA_{1C} in the diagnosis of diabetes with interest – finally some common sense being applied to the diagnosis! So well done. However, you persist in using the term screening badly, and use the absolute nonsense term "opportunistic screening".

There is no such thing as "opportunistic screening". Either one screens – asymptomatic population, acceptable test (sensitive/specific) appropriate intervention, better outcome and all that – or one doesn't. What you are actually referring to is the use of an investigation in a patient who presents in the context of their clinical care. It is not screening, it is a test, with a particular pre-test probability. It needs to be used appropriately, but it is not screening – it is an investigation.

What would be really useful is a rigorous critique of screening – I think you'll find that virtually the only programmes for which there is evidence are cervical screening and the neonatal metabolic tests. The trouble with saying this out loud is that professing the lack of evidence for say, breast cancer screening, will incur the wrath of the politically correct.

Dr Wayne Cunningham,
General Practitioner, Milton

We agree with Dr Cunningham that the use of the word "screening" has shifted over time, and that the appropriateness of the word depends on the context. Screening is a method applied to populations, it is not a test applied to an individual. In future articles we will endeavour to use the term "screening" only in the context of formal population screening programmes such as cervical screening. Instead of "opportunistic screening", we will refer to the practice of offering tests to patients who present for unrelated medical issues as "opportunistic testing". For example, using HbA_{1c} to opportunistically test high risk groups, such as Māori, for diabetes will reduce some of the barriers posed by traditional glucose testing, such as the need to fast.

bpac^{nz} recertification programme

Dear Editor,

A lot of General Practitioners are very upset about the new Medical Council of New Zealand levy to support BPAC and pay for us being (yet again) certified. There is a ground swell of opinion coming from my colleagues that this levy is a "rip off".

The $1200 levy applies to doctors who are not members of the Royal College, and that is a huge number of doctors. Maybe you can tell me how many?

To spring this unpleasant surprise on us without any warning was upsetting. Upset is probably an understatement, angry is more like it with a few of my mates. I really value BPAC but the constant money grabs (beyond just BPAC) is creating unhappy doctors – and I think maybe your PR needs to improve in order to "sell" the whole idea. Perhaps the MCNZ is more responsible here.

We already have over a half a dozen "professional bodies" looking after our "interests", and to have to pay another one really sticks in the side.

Dr Alex Luft
General Practitioner, Napier

Thank you for your comments. The new requirements for general registrants have been signalled by the Medical Council (MCNZ) for a number of years. Last year the council put out a "request for proposal" for organisations to provide this programme. Bpac^{nz} was selected as the preferred provider for this service.

In New Zealand we have three categories of doctors:

1. Those who are vocationally registered in general practice or other specialities
2. Those in advanced training programmes
3. Those in the general registrant category

The MCNZ believe that there are 2000 to 2600 doctors in the general registrant category. One of the reasons for the uncertainty of this number is that not all doctors in advanced training programmes inform the medical council. I understand that there are approximately 800 general registrants working in General Practice.

As you point out, those of us in category 1, pay fees to college(s) and must meet the reaccreditation requirements. Those in category 3 have been required to have a named supervisor and meet requirements associated with this. When the recertification programme begins the requirements will be more rigorous, and as you point out, will cost registrants $1200.

It is my personal wish (and one I know is shared by many in general practice) that this change will focus those in general practice working in the general registrant category, on attaining full vocational registration. I do however understand that for a variety of reasons not all will wish to.

Professor Murray Tilyard
CEO bpac^{nz}

Testing for allergy in general practice

Dear Editor,

I was pleased to see Allergy Testing reviewed in Best Tests (Dec, 2011), but have some concerns. The most important part in treating allergies is recognition and education, and general practice is ideally placed to provide this. Recognition is mainly based on clinical history, but testing can be useful, in particular if wheat, dairy or multiple food avoidance is being suggested for more than a few weeks test period. Dr Vincent St Aubyn Crump has written an excellent guide to diagnosing allergies in General practice which is available at: ***www.allergy.org.nz/site/allergynz/files/GP%20diagnosis.pdf***

My concern is that if the allergy is not accurately diagnosed the patient may not be receiving adequate education. Education should involve action plans, antihistamines (and occasionally adrenaline), avoidance advice and follow-up. Schools are required to have action plans for children with allergies and we will be increasingly asked to complete them, which is a good thing for best practice. The Australasian Society of Clinical Immunology and Allergy (ASCIA) action plans and the New Zealand School Guidelines, along with many other resources, are available at: ***www.allergy.org.nz***

In a recent large study in Melbourne, 10% of the 2,884 one-year-olds had food challenge proven IgE food allergy. Food allergies are increasing, more people have multiple allergies and they are lasting longer. So "containing" the budget as suggested may not be feasible, but aiming to have a balanced approach of judicious testing based on appropriate clinical history from an informed medical workforce is.*

Further resources:

ASCIA provides excellent online training for health professionals, which takes about an hour and is endorsed for CME points: http://etraininghp.ascia.org.au/

There are also two excellent books I would recommend for anyone interested in finding out more, both are also available from Allergy New Zealand:

"Allergies. New Zealand's growing epidemic" by Dr Vincent St Aubyn Crump, 2009.

" The Allergy Epidemic. A Mystery of Modern Life" by Dr Susan Prescott, 2011.

Dr Kylie Morse
General Practitioner Wellington, Allergy NZ board member

* *Osbourne N, Koplin J, Martin P, et al. Prevalence of challenge-proven IgE-mediated food allergy using population-based sampling and pre-determined challenge criteria in infants. J Allergy Clin Immunol 2011;127(3):668-76*

We value your feedback. Write to us at: Correspondence, PO Box 6032, Dunedin or email: editor@bpac.org.nz