**Child health**


**Synopsis:** Speech and language delay in children is associated with difficulties in reading, writing, paying attention and socialising. Prevalence rates vary from between just over two to up to 19% in children aged from two to seven years. Causes may be primary or secondary to hearing problems, disorders on the autism spectrum, intellectual disability and physical speech problems. Risk factors include male sex, pre-term birth, low birth weight, childhood illness and larger family size. The consensus in the US is that there is insufficient evidence to recommend brief formal screening tools in primary care. However, readily accessible speech milestones are suggested for use in the above risk groups and when parents have concerns. Referral to a speech and language therapist and an audiologist is recommended. Therapy is more effective when there is a primary expressive disorder compared to a receptive disorder. Families may aid their children’s language development by telling stories, reading books, reciting rhymes and songs and engaging regularly in questions and answers.

**GP commentary:** Contains a very helpful table of developmental speech and language milestones. Quite informative.

**Reviewer:** Diarmuid Mulcahy

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**Chronic disease**

2451 Chronic hepatitis C virus infection in Swiss primary care practices: Low case loads—high barriers to treatment? Overbeck K et al. Eur J Gen Pract 2011; 17: 103-108.

**Synopsis:** This paper examines the management of chronic hepatitis C (HCV) in a Swiss primary care setting. A sample of primary care physicians (PCP) completed a self-administered questionnaire. The results showed a low case-load per physician, similar to other European countries. Most physicians monitored their chronic HCV patients themselves, but 16% of PCP saw no need for regular monitoring at all. While the majority referred their chronic Hep C patients to a specialist for initiation of treatment, they frequently neglected to adequately work-up HCV patients beforehand. Two-thirds of their chronic HCV patients had not undergone antiviral therapy – a high figure but in line with other studies. Many PCPs cited patient-related factors, such as drug dependence, as barriers to treatment, but studies have shown that antiviral therapy has similar compliance and success rates in these patients provided it is conducted with adequate patient support. The authors conclude that while Swiss PCP management of chronic HCV is lacking in some respects, it is similar to other countries. They recommend that PCP should monitor non-cirrhotic patients with annual transaminase measurements and cirrhotic patients with six-monthly HCC screening and liver function tests. Otherwise, they recommend specialist referral for work-up completion, to evaluate treatment suitability and for support in conducting treatment.

**GP commentary:** This paper highlights worrying gaps in management of chronic HCV in primary care. However, it is limited by its small size and self-selection of participants and its conclusions may not be readily applicable to primary care in Ireland.

**Reviewer:** Una Kennedy
Dermatology
2452 Sunscreen SPFs: clear as daylight? DTB 2011; 49(6): 61. dtb.bmj.com

Synopsis: Recently issued public health guidance on skin cancer prevention from NICE recommends that used properly, a sunscreen with SPF of at least 15 is enough. The problem, though, is that a sunscreen only delivers this degree of sun protection if it is applied to the skin at a thickness of 2mg/cm². NICE says “SPF 15 is sufficient if applied adequately”. This adequate level is difficult to achieve however, is costly and not cosmetically pleasing. A single application typically requiring 35ml of sunscreen, and a 200ml bottle would last only two to three days. This paper feels the NICE advice on sunscreen is not in the interest of public health. It feels an SPF of 30 would be more realistic and representative of the way people actually use and apply sunscreen. The issue of changing the standard for testing sunscreen to represent a more typical application is also suggested. This would really tell people what sun protection to expect on a typical application.

GP commentary: The devil is in the detail. Difficult to believe that SPF factors are based on applications so far removed from your everyday typical application. SPF 30 does however sound a little excessive for our summers!

Reviewer: Derek Gallagher

Gastroenterology

Synopsis: Crohn’s disease is a chronic condition of the gastrointestinal tract, characterised by transmural, granulomatous inflammation that occurs in a discontinuous pattern, with a tendency to form fistulae. The cause is unknown, but may depend on interactions among genetic predisposition, environmental triggers, and mucosal immunity. Symptoms commonly include diarrhoea, abdominal pain, weight loss, blood or mucus in the stool, perineal pain and discharge. Extraintestinal manifestations of the disease include arthritis, uveitis, and skin rash. Internationally accepted criteria for the diagnosis of Crohn’s disease have been defined by Lennard-Jones. The incidence of Crohn’s disease is increasing. It is most commonly diagnosed in late adolescence and early adulthood. It is a lifelong condition, with periods of active disease alternating with periods of remission which causes significant disability. Corticosteroids are first-line treatments to induce remission of acute disease. Budesonide is used in mild to moderate ileocaecal disease, prednisolone or methylprednisolone are generally recommended for more severe disease. Azathioprine and mercaptopurine are effective in inducing remission in Crohn’s disease. Monitoring for myelosuppression is obligatory. Aminosalicylates (mesalazine, sulfasalazine) may reduce disease activity. Methotrexate at a dosage of 25mg weekly increases remission rates and has a corticosteroid-sparing effect. Infliximab is effective in inducing and maintaining remission in Crohn’s disease, but the long-term adverse effect profile is unclear, and it is generally reserved for treatment of refractory disease. Smoking cessation reduces the risk of relapse, and enteral nutrition may be effective. Fish oil and probiotics have not been shown to be effective.

GP commentary: A summary article from the BMJ Clinical Evidence Handbook which gives evidence-based guidance for treatment of this debilitating condition. Worth a read.

Reviewer: Brian O’Dea

Haematology
2454 Update on vitamin B12 deficiency. Langan RC, Zawistoski KJ. Am Fam Physician 2011; 83(12): www.aafp.org/aafp

Synopsis: Vitamin B12 or cobalamin is a water-soluble vitamin essential for red cell synthesis, proper neurological function and DNA synthesis. It cannot be made by humans and must be ingested in animal protein or fortified cereals at a level of at least 2.4µg per day. It is estimated that the prevalence of its deficiency is between three and 12% in those over 50 years. Age as well as risk factors that affect its absorption, namely reduced intrinsic factor levels or disease of the terminal ileum are among the known risk factors for a deficiency. Metformin, antihistamine and proton pump inhibitors may cause a deficiency and vigilance is required. The combined oral contraceptive falsely lowers B12 levels, as well as pregnancy and folic acid deficiency. Vegetarians and those with a high alcohol consumption are at an increased risk of B12 deficiency. Exclusively breastfed babies should be supplemented. In patients with a B12 deficiency and dementia, replenishment of B12 did not improve cognitive function or retard disease progression. Conventional treatment involves intramuscular weekly injections with crystalline B12 for eight weeks and perhaps monthly thereafter. A Cochrane review in 2005 found a similar replenishment following oral ingestion of 1-2mg daily for three to four months.

GP commentary: Reads well. Valuable points of interest.

Reviewer: Diarmuid Mulcahy

Obs & Gynae

Synopsis: Ectopic pregnancy occurs at a rate of about 1-2% of all pregnancies and the diagnosis should be suspected in any woman of child-bearing age who presents with bleeding and abdominal pain, although between 10-20% of women with ectopic pregnancy report no bleeding and almost 10% do not report no abdominal pain. The risk is higher in those with increased maternal age, history of pelvic infection or surgery, infertility, and in those who smoke. Those who become pregnant with an intrauterine device in situ also
have a higher risk, but the authors do not distinguish between progesterone-bearing devices and other IUCDs. They indicate that the best method of diagnosis is by trans-vaginal ultrasound as opposed to trans-abdominal ultrasound and that while blood tests measuring beta HCG and progesterone have a role in monitoring the condition they are not diagnostic of the pregnancy site. The most frequent misdiagnosis is that of gastrointestinal upset in those who have already ruptured and have early peritonism. They concur with the advice that those of us in primary care should seek early referral to a specialist unit rather than embarking on vaginal examination, although there is no evidence of causing rupture to a tubal pregnancy. With regard to its management, the aim should be to preserve future fertility and the options are expectant management, medical management with methotrexate, laparoscopy or laparotomy with salpingostomy where the tube is preserved, or salpingectomy with removal of the tube. The clinical presentation will dictate the options which should be fully discussed with the patient in a non-emergency setting. Rates of spontaneous intrauterine pregnancy post salpingectomy vary between 38-66% while those with tubal conservation vary between 62-89%. The rate of recurrence varies between 6-18%, with a trend towards higher rates after salpingostomy. Fertility outcomes after expectant management and medical treatment with methotrexate are not significantly better than after surgery. The article concludes with a patient’s own story, a useful summary, list of sources used in the review and a list of resources for management guidelines and patient information.

GP commentary: An excellent, well-written, clear and concise review. Useful for all in GP but especially GP trainees.

Reviewer: Genevieve McGuire

Sports medicine

Synopsis: An Australian-based PubMed literature review of RCTs in the last decade. Tennis elbow is usually a clinical diagnosis consisting of tenderness at lateral epicondyle with normal elbow range of motion and pain on resisted movements (especially resisted third finger extension). If the elbow’s range of motion is restricted a different diagnosis should be considered. It typically affects those who change a routine new gym regime/gardening/painting a room etc. Pathology is complex and not fully understood. Healthy tendons act like muscle springs. Sudden overload may alter a tendon’s structure and allow a degenerative process to begin. Overload on a tendon needs to be discontinued. Eccentric (lengthening only) exercises improve pain and function. NSAIDs are useful short-term only (long-term use may have deleterious effects on tendon healing). Cortisone injections should be avoided because while superior in the short-term they are more likely to be associated with a recurrence in longer term. A GTN patch applied over the area showed only short-term benefit over placebo (note dosage used is lower than that in angina so patch needs to be cut). Further research is needed on newer (minimally invasive) treatments, such as autologous platelet rich plasma injections, hyaluronan gel injections and nitrate patches. Reserve surgery and botulinum toxin injection for the worst cases because patients can take six months to return to full function. Lithotripsy may be beneficial.

GP commentary: A useful and interesting review article of a common problem. Bottom line – most cases will naturally resolve within months.

Reviewer: Deirdre Nevin

Urology

Synopsis: Interstitial cystitis is a painful bladder disorder mainly affecting young and middle-aged women. It should be considered in any patient who has had supra-pubic pain or discomfort and urinary frequency, in the absence of infection for more than three months. No infectious organism can be isolated but there is an increase in activated mast cells in the bladder. Some studies suggest that glycosaminoglycans, which form a protective coating on bladder mucosa, may be compromised allowing noxious molecules in urine to activate sensory nerve endings. It is a diagnosis of exclusion once overactive bladder and infection have been ruled out. There may be a history of bladder problems in childhood. These patients can often have chronic fatigue syndrome, vulvodynia, fibromyalgia, endometriosis or panic disorder. Evidence suggests that a significant proportion of these women have been abused, an important consideration to bear in mind. Management includes gynaecological exam, relevant blood tests, urine culture and occasionally urological referral. Petechiae and submucosal haemorrhages may be seen at cystoscopy. Patient education is an integral part of the management of interstitial cystitis. Bladder irritants such as caffeine and alcohol should be avoided as should stress, smoking and spicy foods. Amitriptyline 50-75mg nocte, diazepam, tramadol and gabapentin can all be of benefit. If oral therapy fails, intravesical therapy may be appropriate. Further research is needed on newer treatments, such as autologous platelet rich plasma injections, hyaluronan gel injections and nitrate patches. Reserve surgery and botulinum toxin injection for the worst cases because patients can take six months to return to full function. Lithotripsy may be beneficial.

GP commentary: A useful overview of a condition which is a frequent cause of chronic pelvic pain yet is often under and misdiagnosed.

Reviewer: Martina Collins