

## Breast cancer

### Dear Editor

I have just read the publication *Guidelines for preventive activities in general practice*. It is, as one would expect, excellent. I wish to comment on one area – 8.4 Breast cancer:

1. 'Clinical breast examination is not recommended as a routine for women undergoing regular mammographic screening'.

As in many areas of our society today, there is a clear implication here that tests are infallible – they are not. Breast lumps can also develop in between mammograms. An occasional one of these is malignant, and very occasionally, can be detected clinically.

2. 'All women should be advised to be aware of the normal look and feel of their breasts and to report any new or unusual changes to their GP without delay. There is no evidence that teaching women to undertake regular breast self examination is effective'.

I have difficulty in reconciling these two statements. If the second is true, why is the first one made? Although all the evidence I have seen does seem to dispute the effectiveness of BSE, my experience is that a significant proportion of breast cancers I have seen were brought to my attention by the patient's presenting complaint: 'I've found a lump in my breast'.

As an aside, I have found many more breast and thyroid lumps, skin lesions needing removal, blood pressure problems, and family problems in response to the question: 'And how are things going in general?' than abnormal smears when doing routine Pap tests according to the protocol. Perhaps holistic, patient centred medicine is a valid concept after all.

*David Backstrom  
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## Reply

1. There is lack of evidence for clinical breast examination as a screening measure in itself and or for its use as an alternative to mammography. There is evidence for mammography. Women screened with mammography have lower risk than those who have not. So CBE is even less indicated as a screening tool in this population group. This is the justification for not recommending CBE. It is not saying that mammography is infallible. If a women who has had a negative mammogram

presents with a lump she should be investigated with fine needle biopsy.

2. The second point is more difficult to explain. There is insufficient evidence to support teaching women BSE as part of a population prevention program. This is because women taught BSE are no more likely to detect breast cancers than those who are simply advised to 'be aware of the normal look and feel of their breasts and report any new or unusual changes to the GP without delay'. This might seem counter intuitive but it is what the trials indicate.

*Mark Harris  
RACGP Red Book Task Force*

## Uptake of spirometry training by GPs

### Dear Editor

The majority of patients with chronic respiratory symptoms initially present themselves to their GP.<sup>1</sup> Spirometry is the recommended tool for objectively diagnosing and monitoring asthma in general practice because of its consistency and reproducibility. However, adequate training and education is imperative if GPs are to competently perform spirometry and interpret results.<sup>2</sup> Little is known about the attitudes of GPs toward spirometry training<sup>3</sup> and factors influencing participation.

We have been conducting a cluster randomised controlled trial in South Australia and New South Wales, with 40 practices and 560 patients participating. Half of the practices were randomised into an intervention group where practitioners and staff were educated about their roles in systematic care, spirometry and the Asthma 3+ Plan. Fifty-nine GPs were invited to participate in a spirometry training workshop, but only five (8.5%) attended. In order to understand reasons for or against their attendance, a postworkshop questionnaire was sent to the GPs, which resulted in 50 (84.7%) responses.

The primary driver for those GPs who did attend the workshop was the expectation of gaining a more comprehensive understanding of spirometry results. By contrast, a heavy workload and limited time constraints were the most frequently reported reasons for nonattendance (n=22, 44%). Other reasons were less frequent: five GPs (10%) felt the training would not be of benefit to themselves or their patients; six (12%) lacked spirometers; four (8%) GPs were discouraged as no CPD points were available, and four (8%) had

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recently trained in spirometry. By contrast, 11 (22%) GPs reported they had plans to attend spirometry training in the near future although they did not provide specific details.

It is evident that if spirometry is to be promoted in primary care, education programs must be offered that meet the needs of GPs and address the barriers to their attendance. Relevant educational material should be made available before the program and the training provided through in-practice workshops, or perhaps by on-line or distance learning modes. We also need to clarify whether other staff members should complete this training, if GPs have no time. CPD points are important to GPs, but they also need to be convinced (with appropriate evidence gathered from primary care) that spirometry will make a difference to patient care and that it is cost effective to purchase a machine and perform spirometry regularly.

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## Clinical teaching

### Dear Editor

I enjoyed reading the article on clinical teaching by Professor Molodysky and colleagues (*AFP* January/February 2006).

The authors state that academic leaders rarely expect clinical teachers to have undergone formal or even informal training for this vocation. In fact the academic leaders seldom value or reward those who are good at clinical teaching. Most Australian universities appoint and promote their academic staff for their research work; even

here the preference is for basic research, ie. clinical and teaching skills are largely irrelevant in their system of meritocracy.

I hope the insightful article and the proposal therein for new directions in clinical training will encourage at least some 'leaders' to review their current system.

*A Manoharan  
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## Fetal alcohol syndrome

### Dear Editor

We read with interest the excellent articles on growth and developmental delay in children and adolescents (*AFP* September 2005). We were disappointed to discover however, that alcohol exposure during pregnancy was not discussed as a cause of growth failure and developmental delay.

Alcohol is a teratogen that can have a devastating effect on the developing fetus. The extreme manifestation of exposure to alcohol in utero is fetal alcohol syndrome (FAS), a composite of pre- and/or post-natal growth retardation, characteristic facial features, and structural defects and/or dysfunction of the central nervous system.<sup>1</sup> It is also well recognised that the child exposed to alcohol in utero may present with a wide range of other birth defects, or developmental, psychological, cognitive and behavioural problems in the absence of structural birth defects. This had led to the introduction of a more inclusive term 'fetal alcohol spectrum disorder' (FASD), which is now used to include children with FAS, alcohol related neuro-developmental disorders, and alcohol related birth defects. Although FASD is entirely preventable,<sup>2</sup> our research suggests that some Australian families have more than one affected child, and that opportunities for prevention have been missed.<sup>3</sup>

Our research also suggests that FAS is under-recognised in Australia. This may be due to lack of routine screening of pregnant women and women of childbearing age for evidence of alcohol use, and/or to health professionals' lack of knowledge about and hence ability to diagnose FAS.

The December issue of the *Australian and New Zealand Journal of Public Health*<sup>4</sup>

contains the results of a survey investigating the knowledge and practices of health professionals regarding FAS and alcohol use during pregnancy. Fewer than half of the health professionals surveyed routinely took a history of alcohol use in pregnant patients; only a quarter routinely provided information on the possible harm to the fetus from alcohol; few had diagnosed FAS; and 98% felt ill prepared to deal with a child with FAS. The results of our recent survey of WA paediatricians were similar. There is an urgent need for education of health professionals to address these gaps in knowledge and practice thereby improving prevention and diagnosis of FAS.

We strongly support the commissioning of articles on alcohol use during pregnancy and FASD to help address knowledge gaps in Australia's family physicians.

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