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GPPARTNERS' BULLETIN

November 2013
Volume 2, Issue 9

From the Chair ……

Since the last newsletter GPpartners has had an education evening about Allergies with Dr Paul Campbell. The evening was well attended with very positive feedback. A summary of the presentation is included in this newsletter. Again I am surprised how quickly knowledge is changing in medicine. If you are like me you will find some new concepts in the summary on Allergies.

It was timely having the presentation on knees by Dr Gaugin Gamboa last month. Now GPs are able to order MRIs for knees in acute injuries under Medicare. The presentation tells us when to order further investigations and when we need to refer to an orthopaedic surgeon. Dr Gamboa's presentation is available on our website **www.gppartners.com.au** .

On Wednesday at St Lucia QML is hosting an evening to talk about the new faeces PCR testing and all you wanted to know about Legionella. I have used the test on some patients with recurrent diarrhoea and was surprised to find they did have pathogens despite previous microscopy and cultures being negative.

We are starting our planning for educational events for next year. If there are any topics you would like covered or if you have a special interest and would like to volunteer to present at a meeting please let us know at **contact@gppartners.com.au** .

As well as providing education the GPpartners Board hope that GPs are able to network and discuss issues at the meetings.

I have spoken to a couple of GPs recently who didn't realise that GPpartners is still functioning. Please spread the word that we are still here and working as a GP membership organisation for education and advocacy on local issues. Even better, ask them to go to our website and join as a member with the easy online membership form.

Jayne Ingham

Meet our GPpartners Directors:-

A/Prof Glynn Kelly
Dr Sarah Cavanagh
Dr Jayne Ingham
Dr Henry Bryan
Dr Deborah Sambo

Boning up on Knees.

Dr Gauguin Gamboa, Orthopaedic Surgeon presented at the North Lakes Day Hospital about acute knee injuries and what GPs should do. The knowledge has certainly changed since I went to Med School.

We have now added his notes to our website:-

Presentation—Soft Tissue Injuries of the Knees

Date Claimers

13th November

"Big news on Tummy Bugs and others"

Hillstone, St Lucia.

Invitations out soon!

Register online at

www.gppartners.com.au

GPPARTNERS MEMBERSHIP

Our numbers are growing and the more GPs we have as registered members, the bigger the VOICE we will have…..

JOIN NOW

Free until 30 June 2014

Click on link below

www.gppartners.com.au/membership

CPR TRAINING

Have you done your CPR training for this triennium?

If you haven't, RACGP is arranging CPR courses. Contact Justine Watterson on 3456 8902.

If you are unable to get to the RACGP course email GPpartners contact@gppartners.com.au and register your interest.

B.L.S. First Aid Training will do a session if there are 8 GPs at a cost of $45 pp.

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"ALLERGY DESENSITISATION in the 21st Century & an Anaphylaxis Update"

On 30th October, GPpartners hosted a well attended presentation by **Dr Paul Campbell from the Wesley Hospital** on anaphylaxis and allergy desensitisation with 38 GPs in attendance.

The presentation was high quality and most informative to all attendees. Some salient points included:

Desensitisation

Oral immunotherapy (in appropriate doses) approximately equivalent to subcutaneous immunotherapy in benefits with minimal risk of anaphylaxis (something like 1 in 1 billion possibility)

Dr Campbell emphasised the importance of known anaphylaxis sufferers having an individualised self anaphylaxis plan (pro-formas available on: http://www.allergy.org.au/health-professionals/anaphylaxis-resources/ascia-action-plan-for-anaphylaxis

Anaphylaxis

1. Triggers for anaphylaxis food allergy

* food allergy is rare, but commoner in children than in adults
* among the more common food triggers are:

Egg white Nuts and pulses Crustaceans

Mammalian meat – this is to be noted and has some association with tick sensitisation

Milk and dairy food

2. Bites and stings

* main culprits are bee venom, wasp venom, tick bite & Australian Jumper Ant venom. (Jumper ants are in evolution between an ant and a wasp)
* Jumper Ant immunotherapy available in some centres
* may also be associated with any type of snake envenomation.
* may follow periods of 'crescendo' reactions
* RAST tests available for honey bee, paper wasp, yellow jacket (common wasp) and Jumper Ant only: however, positive in ~10% normal immunotherapy (bee & wasp) extremely effective (95% response rate), but 3% will have anaphylaxis during treatment, so hospital based.

Dr Campbell also made the point that removing a tick in our surgery can precipitate anaphylaxis if the patient has become sensitised.

3. Physical urticaria

* triggers include cold, pressure and heat
* may be associated with bronchospasm, angioedema, hypotension and collapse (especially in cold urticaria)
* sometimes associated with systemic disease (eg EBV, varicella, hepatitis, cold agglutinins, cryoglobulins, syphilis and leucocytoclastic vasculitis)

(Note: if a person with cold urticarial goes swimming in cold water they can die from anaphylaxis and circulatory collapse)

4. Food chemical intolerance

* rare in children
* non-IgE mediated
* caused mainly by hypersensitivity to pharmacological effects of natural food chemicals (eg salicylates and amines)
* quantitative effect
* no tests available
* may be detected as aspirin hypersensitivity

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Management of anaphylaxis:-

- Preserve airway, breathing and circulation:
- oxygen if available
- intramuscular adrenaline: 0.3-0.5ml of 1:1000: repeat every 5 mins prn
  - ⇒ reduces blood flow and transudation of fluid across affected capillaries, thus preventing further reduction in blood volume; increases peripheral resistance, thus reversing hypotension bronchodilator effect reverses bronchospasm)
- subcutaneous absorption erratic; intravenous administration dangerously arrhythmogenic
  - ⇒short acting, and does not inhibit ongoing action of released histamine
- antihistamine: parenteral or oral, depending on availability:
  - ⇒ use asap & continue a regular dose of oral formulation for 3 days after event
- steroids, nebulised bronchodilators, intravenous fluids:
  - ⇒ oral prednisolone 1mg/kg stat and daily for 3 days after event
  - ⇒ (can also use parenteral hydrocortisone if iv access available)
  - ⇒ nebulised salbutamol prn
  - ⇒ v fluids

Measles in returned travellers – including those returning from Bali Information for Clinicians

Important information

Since October 2013, there have been 27 measles cases in Australians, including 11 secondary cases, associated with travel to Indonesia, and more specifically Bali. In addition to the hundreds of thousands of Australians who travel to Bali throughout the year, a number of teenagers and young adults are expected to travel to Bali for "Schoolies" celebrations occurring from mid-November to mid-December 2013. Updated advice for travellers is found on the Smartraveller website (http://www.smartraveller.gov.au/).

Clinicians can support efforts to prevent measles by advising measles vaccination prior to travel if indicated, and being aware of the symptoms, appropriate laboratory investigations and notification requirements for suspected cases of measles.

Key points for Clinicians

- Recommend at least one, ideally two doses of measles-containing vaccine for individuals planning to travel to countries with known endemic measles (including Indonesia), who were born during or since 1966, and do not have documented evidence of prior two dose measles vaccination or serological evidence of immunity.
- Consider the possibility of measles in patients with rash and fever and any of cough / coryza / conjunctivitis, with an onset of 18 days or less since return from measles-endemic countries, including Indonesia.
- Minimise the risk of transmission within your department or practice through immediate isolation of suspected cases.
- Take blood for serological confirmation in all suspected cases. For early diagnosis, seek approval for PCR testing of nose and throat swabs from your relevant Communicable Disease Control Department/Unit (contact details provided below). Approval is required as measles PCR testing does not attract a Medicare rebate.
- Notify the relevant Communicable Disease Control Departments/Units of all suspected and confirmed cases (contact details provided below)

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Measles in returned travellers – including those returning from Bali

Who is at risk of measles?

Children or adults born during or since 1966 who do not have documented evidence of receiving two doses of a measles-containing vaccine or documented evidence of laboratory-confirmed measles are considered to be susceptible to measles. People who are immunocompromised are also at risk.

Individuals described above planning to travel to Bali and other overseas destinations where measles is present.

Individuals described above recently returned from overseas destinations where measles is present and those in contact with them.

What are the symptoms?

- Clinical features of measles include a prodrome of fever, cough, conjunctivitis and coryza. A characteristic generalized maculopapular rash then appears on the third to seventh day of illness.
- The *incubation period* is variable and averages 10 days (range: 7 – 18 days) from exposure to the onset of fever, with an average of 14 days from exposure to the onset of rash. The *infectious period* of patients with measles is taken as five days before, to four days after, the appearance of the rash.

What laboratory investigations are required for suspected cases?

- Take blood for serological confirmation in all suspected cases. If a patient has measles, IgM is generally positive if the rash has been present for three or more days. IgG in the absence of IgM indicates the patient is protected and means measles is unlikely.
- For early diagnosis (including prior to rash), nose and throat swabs for PCR testing is possible. PCR testing does not attract a Medicare rebate therefore you must contact the your public health or communicable disease control unit to gain approval for these (contact details provided at end of this information sheet)

What are the recommended infection control measures for patients?

Measles is transmitted by airborne droplets and direct contact with discharges from respiratory mucous membranes of infected persons, and less commonly by articles freshly soiled with nose and throat secretions. Measles can persist in the indoor environment for up to two hours.

Minimise the risk of measles transmission within your department or practice:

- avoid keeping patients with a febrile rash illness in shared waiting areas;
- give the suspected case a single use mask and isolate them, until a measles diagnosis can be excluded;
- leave vacant all consultation rooms used in the assessment of patients with suspected measles for at least two hours after the consultation.

The Royal Australasian College of General practitioners (RACGP) provides infection control standards for office-based practice (http://www.racgp.org.au/your-practice/standards/infectioncontrol/). Health care workers should follow the NHMRC: Australian Guidelines for the Prevention and Control of Infection in Healthcare - 2010 - External Link

Contact details for Communicable Disease Control Departments/ Units:

Queensland 13 432 584

Contact details for the public health offices in QLD Area

www.health.qld.gov.au/cdcg/ contacts.asp

Further information

The Australian Immunisation Handbook; 10th edition, 2013.
http://www.health.gov.au/internet/immunise/publishing.nsf/Content/EE1905BC65D40BCFCA257B26007FC8CA/$File/handbook10.pdf

Checkup (previously General Practice Queensland) has asked GPpartners to distribute this survey. There is a chance to win a coffee machine and an offer of 10% off for Merlo coffee.

The survey is now open and can be accessed through this direct link - **https://www.surveymonkey.com/s/CheckUPCensus2013**