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## Is “nut-free” sunflower seed butter safe for children with peanut allergy?

Mimi Tang and Raymond J Mullins

**TO THE EDITOR:** In their report of a child with peanut allergy who developed sunflower seed allergy, Hsu and Katelaris caution against marketing claims of “safe alternatives” in allergic children.<sup>1</sup> Their report also raises practical issues for those advising the parents of a child with food allergy: what is the risk of a new allergy developing; should a child with peanut or tree nut allergy avoid similar foods as well; and will food avoidance prevent new allergy from developing?

The natural history of peanut and tree nut allergy is for polysensitisation to develop over time. One study demonstrated that, in children younger than 2 years with peanut or tree nut allergy, 19% were sensitised and 2% were clinically reactive to more than one nut.<sup>2</sup> By the age of 14 years, the percentages had risen to 72% and 47%, respectively. This has led to people with peanut or tree nut allergy being advised to avoid all nuts and seeds.<sup>2</sup> Strategies commonly advised to reduce the risk of allergy developing are to avoid food allergens and to delay the introduction of allergenic foods until the age of 2 years, but evidence to support their effectiveness is limited,<sup>3</sup> particularly for preventing food allergy.<sup>4</sup>

While studies in infants at high risk of allergic disease have reported an increased risk of eczema with early introduction of solids (before the age of 3–4 months),<sup>3</sup> and a protective effect against asthma and eczema with the avoidance of environmental and food allergens in the first 6 months of life,<sup>4</sup> a recent systematic review found “no strong evidence to support the association between early solid feeding and the development of persistent asthma, persistent food allergy, allergic rhinitis, or animal dander”.<sup>5</sup> Furthermore, there is currently no evidence that avoidance strategies applied beyond 6 months of age are effective for allergy prevention, and provisional evidence that such strategies might actually promote sensitisation and food allergy rather than tolerance.<sup>6</sup>

So how should we advise patients?

The peanut and tree nut avoidance strategies advised will be largely dictated by:

- choking hazards in infants;

- the risks of cross-contamination in commercially prepared foods; and
- the potential for confusion in young children (and caregivers) trying to differentiate one “nut” product from another.

Regarding the risk of developing new food allergy, we should advise patients that:

- new allergies may develop with time;
- this risk is unpredictable;
- we have little evidence to recommend avoidance beyond the age of 6 months as an effective preventive strategy; and
- parents should not be optimistic (given the current state of knowledge) that such strategies will prevent new sensitisation once food allergy has developed.

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1 Hsu DC, Katelaris CH. Is “nut-free” sunflower seed butter safe for children with peanut allergy [letter]? *Med J Aust* 2007; 187: 542-543.

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## γ-Hydroxybutyrate poisoning from toy beads

Vicki Kotsirilos

**TO THE EDITOR:** The case reports presented by Gunja et al<sup>1</sup> are a serious concern from many perspectives. The health authorities should be commended for their rapid risk assessment and alerting the community, which led to the immediate withdrawal and recall of the toy beads from the marketplace.

However, the question needs to be asked: Could this situation have been prevented, and if so, how? There are many toys in Australia that potentially pose risks to child-

ren. These can include physical dangers, such as the size of toys, with risk of choking, to toxicological dangers, as we have seen with Bindeez toy beads (containing 1,4-butanediol), and psychological and social concerns, such as the effects of sexually provocative toys on young girls and “aggressive” toys (which may encourage violence) on young boys. More research is required to test the psychological influence of such toys on children. The evidence should be used in the development of guidelines for safer toys.

At present, toy manufacturers in Australia must adhere to the Australian Toy Standard (AS/NZ 8124), established by Standards Australia.<sup>2</sup> Toys are monitored and regulated mostly by the state governments. While the manufacturers are expected to adhere to these standards, they are in fact voluntary standards and self-regulated, and many toys can enter and be sold in Australia without meeting these standards.

When a consumer or state government inspector is concerned about the safety of a toy, or if it violates the regulation, they may contact one of the state offices of fair trading, which have the power to remove the toy from the marketplace. This is essentially a post-hoc auditing system and plays an important role in safety, but action is essentially taken after a problem is detected, such as is the case with the Bindeez toys.

In view of potential concerns, I believe what we need in Australia are stronger regulations and guidelines that we can provide to manufacturers to help produce safer toys. Our efforts should be towards preventing any potential harm by strengthening existing regulations, establishing consistent national and international standards for all imported toys, providing more resources for the verification and testing procedures and more expertise and wider consumer input into the safety and suitability of the types of toys permissible in Australia. We have a duty to protect and safeguard our children from both psychological and physical dangers.

**Acknowledgement:** I thank the *MJA* reviewers for their guidance and comments.

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1 Gunja N, Doyle E, Carpenter K, et al. γ-Hydroxybutyrate poisoning from toy beads. *Med J Aust* 2008; 188: 54-55.

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## Osteoarthritis — the forgotten obesity-related epidemic with worse to come

Margaret A Allman-Farinelli,  
Robert J Aitken, Lesley A King and  
Adrian E Bauman

**TO THE EDITOR:** Australia, like many other nations, is experiencing an epidemic of overweight and obesity. The most recent National Health Survey reported that 62% of men and 45% of women were overweight or obese.<sup>1</sup> Among numerous associated concerns is the cost burden of obesity-related illnesses on individuals, the community and the health system.

Among the 45–54-years age group (the stage at which osteoarthritis becomes a significant health problem), we calculated the population attributable risk (PAR) for osteoarthritis associated with obesity to be 25% for men and 22% for women, using a relative risk (RR) of 2.4 and obesity estimates of 23.3% for men and 20.1% for women. In terms of major health sequelae of the epidemic, this is second only to obesity-related type 2 diabetes (RR, 3.2; PAR, 34% for men, 31% for women). Some obese patients will have multiple obesity-related comorbidities.

In 2005 in Australia, 2551 national hospital separations among people aged 45–54 years were for obesity-related osteoarthritis.<sup>2</sup> Using data from the three most recent National Health Surveys, we projected the likely prevalence of obesity among 45–54-year-old Australians in 2025<sup>1,3,4</sup> and then estimated future hospital separations and direct health system expenditure, using costing information supplied by the Australian Institute of Health and Welfare.<sup>2</sup> We project that in 2025, if Australians born between 1971 and 1980 maintain their current rate of weight gain, the proportion of

obese 45–54-year olds will rise to 38.8% of men and 32.2% of women. The estimated number of hospital separations for obesity-related osteoarthritis will increase to 4216. The direct health system cost (in current dollars) will rise to \$44.4 million, from an estimated \$25.5 million in 2005.

The 45–54-year-old population comprises a considerable proportion of the workforce, and obesity-related illness impacts on absenteeism<sup>5</sup> as well as individuals' and families' quality of life. As the current generation of young adults ages, a trend toward increasing illness arising from high levels of obesity is likely, unless health and government policy initiatives to prevent weight gain are given higher priority.

**Acknowledgements:** We thank Mr John Goss from the Australian Institute of Health and Welfare for supplying additional disaggregated costing information and the Australian Bureau of Statistics for supplying National Health Survey confidentialised unit record files. The New South Wales Centre for Overweight and Obesity is funded by NSW Health.

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<sup>1</sup> Australian Bureau of Statistics. National Health Survey: summary of results 2004–05. Canberra: ABS, 2006.

<sup>2</sup> Australian Institute of Health and Welfare. Principal diagnosis data cubes 1988–89 to 2004–05. [http://www.aihw.gov.au/hospitals/datacubes/datacube\\_pdx.cfm](http://www.aihw.gov.au/hospitals/datacubes/datacube_pdx.cfm) (accessed Dec 2007).

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## Radiographers' role in radiological reporting: a model to support future demand

Jeffery M Peereboom

**TO THE EDITOR:** I write in response to two articles published recently in the Journal.<sup>1,2</sup> Both propose that substitution of doctors with paramedical professionals is reasonable.

I disagree. I think it is imperative that before doctors decide to only see the “fun” patients, we had better be sure we want to surrender our status in the health care system.

In the report by Oldmeadow and colleagues,<sup>1</sup> as a result of workload constraints, the proposition is made to have physiotherapists run and manage an orthopaedic clinic.

By the patient-to-doctor ratio in the study, the average load per week for each doctor was four new and five old patients in a 3-hour clinic. Perhaps readers will compare that load with their own.

The study's outcomes are a cause for concern. Recommendations for management and treatment by two physiotherapists were compared with those of an orthopaedic surgeon. If the surgeon's opinion is deemed to be correct, then over 25% of the patients who attended these clinics would have been treated incorrectly. In addition, 13% of the physiotherapists' assessments were not only wrong, but the management plans did not include referral to the surgeon.

Remember, this was a highly artificial, simplified clinic treating a limited range of conditions. Consider what the error rate would be in an open clinic with no restrictions on the patients to be seen.

In the same issue of the Journal, Smith and Baird proposed that radiographers are qualified in some way to read images.<sup>2</sup> While radiographers are skilled technicians, in no way would their interpretive skill be equal to that of a general practitioner, radiologist, or consultant in any other specialty.

We should not lower standards for the sole reason of speed of access.

I would advocate focusing on consolidating the education of GPs, and so empower them as a group. GPs with special interests could equally act as the gatekeepers to clinics.

It is unfair to foist the decisions on care, which are our duty, onto other professionals who are not as extensively trained as we. The job of a surgeon is not to operate on

### Correspondents

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patients. It is rather to organise the care of patients who have a problem in the area of our speciality.

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1 Oldmeadow LB, Bedi HS, Burch HT, et al. Experienced physiotherapists as gatekeepers to hospital orthopaedic outpatient care. *Med J Aust* 2007; 186: 625-628.

2 Smith TN, Baird M. Radiographers' role in radiological reporting: a model to support future demand. *Med J Aust* 2007; 186: 629-631. □

### Tony N Smith

**IN REPLY:** Peereboom appears to ignore reality. Recent news media<sup>1</sup> gave an insight into the state of radiological services at some Sydney teaching hospitals. Thousands of images have never been seen by a radiologist. Yet, *all* of those images were seen by radiographers, who also saw the patients. I am frequently asked by doctors for my opinion about radiographs. At times, I volunteer my opinion to junior doctors and general practitioners. Thirty years of experience tells me that, if I don't, they miss abnormalities, delaying treatment and decreasing the quality of care.

Peereboom will have worked with radiographers capable of accurately interpreting radiographs. Today, many Australian radiography students have tertiary entrance scores in the 90s. Arguably, the only reason we cannot teach them to formally give their opinion on radiographs is because of a professional boundary drawn in the sand in the 1920s.<sup>2</sup> However, the sand is shifting under the health care system.

I have the greatest respect for radiologists' knowledge, skills and intellectual capacity. However, an advanced practice role for radiographers is not just about respect. It is a human resource issue. Knowing that the current service model is antiquated, do we wish to limit the potential of both radiographers and radiologists in the future?

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1 Patty A. X-ray backlog: patients at risk; hospital woes. *Sydney Morning Herald* 2007; 6 Oct: 1.

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## Experienced physiotherapists as gatekeepers to hospital orthopaedic outpatient care

**Caroline A Brand, Richard H Osborne, Ian P Wicks and Richard N de Steiger**

**TO THE EDITOR:** We read with interest the recent article by Oldmeadow and colleagues.<sup>1</sup> Patients on waiting lists have long waits and poor quality of life,<sup>2</sup> and we are currently piloting a similar model for assessment of patients referred for orthopaedic opinion for hip and knee arthroplasty.<sup>3</sup>

In keeping with other authors, the article by Oldmeadow and colleagues provides encouraging data to support role substitution. However, we suggest that important issues need to be addressed before wide-scale adoption and expansion of the model.

More information is needed about the proportion of *all* referred patients eligible for the physiotherapist assessment, and the cost-benefit figures for "avoided" orthopaedic consultations. It is quite difficult to evaluate the outcomes given the exclusion criteria, which are common comorbidities in these settings. While the  $\kappa$  statistic implies concordance between two physiotherapists and one surgeon, the disagreement was still about one patient in four. Of course, this level of disagreement may also be found between surgeons. However, for a new health intervention, such discordance needs to be understood within an appropriate evaluation framework.

What level of diagnostic error are consumers prepared to accept from any health care provider? The article reports five episodes of disagreement between the physiotherapists and the surgeon, where the need for surgery, medical treatment or further imaging was missed; this represents 13.2% of patient assessments (were there multiple missed opinions in individual cases?). The fact that a patient refused surgery is irrelevant if that decision was not identified a priori before surgical referral. Every consumer has the right to accept or reject recommendations about care based on the best available information about potential benefits and harms.

An important role of specialist medical providers is that of diagnostician, particularly when there are multiple or complex conditions. Changes to the management of common musculoskeletal conditions should not reduce opportunities for expert input when required.

Waiting times for many patients are clinically and ethically unacceptable and we agree new service delivery models are necessary. We suggest that:

- professional groups work together to develop agreed evidence-based protocols for triage, assessment, investigation and management of common musculoskeletal conditions;
- funding providers and health care organisations develop and evaluate new models of care, including their cost-effectiveness, and provide appropriate training and monitoring to ensure role redefinition is associated with maintenance of equal or better quality and safety of care; and
- a musculoskeletal clinical network be developed to support these objectives.

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Leonie B Oldmeadow, Harvinda S Bedi, Hugh T Burch, Jenni S Smith, Edmund S Leahy and Miron Goldwasser

**IN REPLY:** The proportion of patients who, after being referred to specialist orthopaedic surgeons by general practitioners, are then listed for surgery, is around 20%–30%.<sup>1–3</sup> In our trial, the diagnostic and management concordance between the physiotherapists and surgeon for this group was very high. It was also high for the 63% for whom evidence-based physiotherapy was appropriate. Management discordance occurred when surgical treatments that are controversial, and variously used by surgeons (as noted by Brand and colleagues), were recommended. It is important to note that the 74% agreement between the surgeon and physiotherapists in our trial was achieved under research conditions, with the physiotherapists screening independently. We suggest that the physiotherapist clinic be co-located with that of the surgeons, to facilitate further investigations, enhance the pathway to surgery and manage safety concerns.

The advantages of a physiotherapist screening clinic are in (i) triaging *out* from waiting to see a surgeon, patients predicted to benefit from non-surgical interventions (including those not willing to consider surgery at the time) and (ii) triaging patients *in* to the appropriate non-surgical care. We agree that patients with degenerative, osteoarthritic conditions, for whom joint replacement surgery may be the eventual treatment, will be best managed through multidisciplinary care.

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## Lack of consistency in safe-sleeping messages to parents

Sarah J Buckley

**TO THE EDITOR:** The concerns expressed by Byard and colleagues about “safe-sleeping messages”<sup>1</sup> are based on the assumption that bed-sharing (mother and baby sleeping on the same bed surface) is intrinsically dangerous.

While some case–control studies have shown increased mortality for young (but not older) bed-sharing babies of non-smoking mothers, more detailed studies have found excess risk only among parents affected by alcohol, extreme overtiredness, overcrowded housing, or where the sleeping environment was unsuitable, including prone or side sleeping, heavy bedding, waterbeds and sofas.<sup>2</sup>

Epidemiological studies support the safety of bed-sharing. For example, in Hong Kong and mainland China, bed-sharing is very common, but rates of unexpected infant death are extremely low. This implicates aspects of Western lifestyle and sleeping practices — including the V-shaped pillows (tri-pillows) highlighted by Byard et al, other suffocation and entrapment hazards, and maternal smoking — rather than bed-sharing per se.

Bed-sharing is also the evolutionary norm, providing many opportunities for “mutual regulation” of maternal–infant physiology, including body temperature, sleep cycle and breastfeeding.<sup>3</sup> Modern bed-sharing mothers may appreciate the more restful sleep and easier breastfeeding.

Overnight sleep laboratory studies of bed-sharing and solitary-sleeping mother–baby pairs show that bed-sharing mothers are very aware of their baby’s presence, even in deep sleep, and move to avoid overlaying. Bed-sharing babies breastfeed more frequently, but with equivalent total sleep for mother and baby.<sup>3</sup> Researchers note the rarity of unsafe prone positions among breastfeeding, bed-sharing infants.<sup>3</sup> Other studies have shown increased rates and duration of breastfeeding among bed-sharing mothers and infants.<sup>4</sup>

For these reasons, bed-sharing has become more popular in Western cultures, with an Australian survey in 2000 finding around 40% of young babies bed-sharing for at least part of the night.<sup>5</sup>

As with other aspects of care, it is our duty as health professionals to discuss the risks, benefits and practicalities of bed-sharing so that parents can make an

informed and safe choice. The Royal Australasian College of Physicians comments, “Co-sleeping or bed-sharing is common and associated with increased breastfeeding rates, longer and more restful sleep, and a protective posture and synchrony of mother with baby . . . All parents should be informed about how to safely co-sleep with their infants”.<sup>6</sup>

Safe bed-sharing recommendations are available from websites such as the UNICEF UK Baby Friendly Initiative.<sup>7</sup>

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1 Byard RW, Cains G, Noblet H, et al. Lack of consistency in safe-sleeping messages to parents [letter]. *Med J Aust* 2007; 187: 62.

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Roger W Byard, Glenda Cains,  
Helen Noblet and Maxine Weber

**IN REPLY:** Our position on bed-sharing was not based on the assumption that it is intrinsically dangerous, but that there is an increased risk of mortality for bed-sharing babies of “parents affected by alcohol, extreme overtiredness, overcrowded housing, or where the sleeping environment was unsuitable” (to quote Buckley). These risk factors were not mentioned by the telephone health advice line quoted in our letter,<sup>1</sup> which rather commented that mortality in bed-sharing babies was such a rare event that the caller should not worry about it — little consolation if a fatality occurred.

We agree completely that parents need to be able to “make an informed and safe choice”, but this also requires informing

them of potential dangers — which did not happen. Also, we do not agree that mothers are always aware of the presence of their babies, as reports of accidental suffocation during breastfeeding in bed clearly demonstrate.<sup>2,3</sup>

An informed decision is made when all the information has been provided, not just information that supports a particular point of view. Curiously, Buckley's final point is to recommend a website for safe bed-sharing advice<sup>4</sup> that states quite clearly (with italics): "the safest place for a baby to sleep is in a cot by your bed". We concur.

Roger W Byard, George Richard Marks  
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1 Byard RW, Cains G, Noblet H, et al. Lack of consistency in safe-sleeping messages to parents [letter]. *Med J Aust* 2007; 187: 62.

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with numerous medications, but often require more support to be provided when at home. My training has taught me to solve problems and resource answers using multiple modalities and resources, at the same time keeping abreast of rapidly evolving medical theories and treatments.

I do so while also facing the current economic challenges of rising insurance premiums, housing costs, and concerns about global warming.

I did not learn Greek or Latin at school, but I did learn to touch type, design a database and formulate a spreadsheet. In my day, when electronic interfaces involved with patient care are changing rapidly, these skills have greatly enabled me for work in the 21st century.

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## In my day

Sara L Barnes

**TO THE EDITOR:** Since graduating from medical school in 2004, I have dutifully read the *Medical Journal of Australia*. I was initially intrigued to read sporadic letters to the Editor in which authors, when commenting on current issues in medical education and clinical practice, referred to what happened "in our day". Topics have included anatomy (eg, dissections), Latin and Greek lessons, teaching methods and hours worked.

At times, I feel that the new generation of doctors, of which I am a part, must justify how we can work as medical professionals given our presumed inadequate knowledge. I believe that the skills I learned while at university have enabled me to successfully manage patients who not only have complex medical problems treated

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