MEDICAL SCHOOLS
POLICY ON THE RUN

The number of medical school places for Australian students is capped. This policy has been sustained by manageable workforce issues, the fear that increasing the number of graduates would blow out the healthcare budget, as well as a carrot for universities — overseas full-fee-paying students. In 2003, the latter accounted for 1 in 6 of our medical students — as many as 1 in 3 in some schools — and these students paid annual fees averaging $30 000.

Amid the current medical workforce crisis, our politicians are now playing catch-up. New medical schools are dropping like manna from heaven — six, no less! Significantly, John Howard recently commented that Australia was becoming more like America — more entrepreneurial — a trend he encouraged. But where does that leave our medical schools?

United States college graduates traverse the US for medical school interviews, and the increasing number of medical schools in Australia will encourage similar behaviour. Previously, overseas full-fee-paying students had to leave Australia after graduation. Now they can stay, courtesy of workforce shortages. There is also talk of fee-paying Australian students, and we have “private” medical schools.

These developments, in turn, foreshadow US-style loans, forcing graduates to pursue fiscally rewarding specialties in order to reduce their debt. Perhaps the prospect of six-figure debts will be a deterrent to studying medicine.

The US has a two-tiered system, wherein prestigious medical schools attract the best students and staff. Critical to the success of these schools is endowed, expansive and expensive infrastructure. Our limited resources and healthcare infrastructure forebode a similar two-tiered system here.

Expanding medical schools in the US would undoubtedly be preceded by expert and public consultations on the value of increasing the capacity of existing schools compared with establishing new schools. Apparently, our politicians do not need such fact-finding.

It seems the Americanisation of Australia still has some way to go.

Martin B Van Der Weyden
Self-inflicted superglue injuries

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TO THE EDITOR: We are concerned about the recent number of patients presenting to our hospital after accidentally applying superglue to their eyes. Of the four cases in February and March 2004, two arose from patients mistaking cosmetic nail adhesive for their regular ocular lubricant, and applying it to the inferior ocular fornices, creating a tarsorrhaphy.

Superglues are cyanoacrylate derivatives. Those used domestically are lower-alkyl derivatives than those designed for medical use and have higher tissue toxicity. The two patients who mistook nail glue for ocular lubricant both required surgical separation of the upper and lower eyelids, and both had significant corneal abrasions, periocular dermatitis and temporary loss of lashes as a result of the reparative surgery. Both were treated with chloromycetin ointment until the abrasions had healed.

We examined the bottles containing the nail adheres. They were remarkably similar to many ocular lubricant bottles, with no significant difference in size, colour or feel (Box). As both products are often kept together in a cosmetics area of the bathroom, accidental ocular application can occur. Similar cases have been reported in other countries over the past 20 years.1–3

The risk of accidental ocular (or potentially aural) application could be reduced by changes to bottles containing superglue, including:
• childproof cap to prevent conventional opening of the bottle;
• colour coding of the bottles;
• different bottle shape; and
• distinctive odour and/or colouring of the glue.

Revisedon of guidelines for the management of gestational diabetes mellitus

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TO THE EDITOR: Consensus guidelines for the management of gestational diabetes mellitus (GDM) were prepared by the Australasian Diabetes in Pregnancy Society in 1997–1998 and subsequently published in the Journal.1

Since that time, there have been two minor revisions to these guidelines. The first, in relation to the recommended frequency of follow-up testing of women identified as having GDM, was detailed in a letter to the Editor in 2002.2

The second concerns the timing of delivery of women with GDM. At the request of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the original recommendation that “continuation of the pregnancy in uncomplicated GDM to 10 days beyond term is acceptable provided that indications from fetal monitoring are reassuring” has been modified by replacing “10 days beyond term” with “full term” to bring this into line with current practice.

The initial guidelines were arrived at by consensus of Australasian practitioners involved in the care of women with GDM. The Australasian Diabetes in Pregnancy Society recognised, both at the time and subsequently, that the level of evidence available to guide clinical decision-making fell well short of that necessary for a definitive statement on the timing of delivery.

It is noteworthy that no international consensus exists concerning the optimal timing of delivery in pregnancies complicated by GDM. The American Diabetes Association, in its Clinical Practice Guidelines, recommends delivery “during the 38th week . . . unless obstetric considerations dictate otherwise.”3 The European Association of Perinatal Medicine does not make a recommendation, instead stating that “the optimal time of delivery and need to induce labour are still controversial.”4

There is currently a paucity of quality evidence on which to confidently base recommendations. We hope that current studies, such as the Australian Carbohydrate Intolerance in Pregnancy Study and the Hyperglycemia and Adverse Pregnancy Outcome Study,5 will provide this evidence.


“Doctor shoppers”: at risk by any other name

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TO THE EDITOR: The article by Martyres et al on drug-seeking behaviour by young heroin users, leading to the deaths of 202 people over 5 years, leads to an inescapable conclusion. Too often, the medical profession is part of the problem rather than the solution, and as a result young people die. Here is an issue where the admonition primum non nocere should be foremost in our practice.

After working with drug users and prescribing methadone for 22 years in a variety of settings, my experience is that drug users use drugs! Whether it is logical, safe or appropriate, or not, this group seeks drugs to modify or modulate their state of being. They often have serious medical and mental health issues, but have sadly decided on their preferred treatment without much knowledge of the diagnosis or of alternative interventions. They are often very skilled in obtaining drugs.

So, we must perform our role equally well. Doctors are not drug dealers. Our duty is not to promote or support intoxication, or even relaxed happiness if that increases the risk of misadventure. It is to promote and support health. It is difficult to see how a prescription for 50 benzodiazepines to a young person (or even an older person) can ever be construed as healthcare. To do it again next day, next week, on and on, is almost unbelievable, yet the data indicate that is exactly what is happening. Even publicans have rules prohibiting serving intoxicated patrons.

That one was “offering the customer what he asked for”, a common excuse for this sort of prescribing practice, would not be a suitable defence in the Coroner’s Court if insulin, digitalis, or even vitamin A, had been prescribed on request. But appeals to good practice and commonsense, along with current regulatory strategies, are apparently not sufficient to protect this vulnerable group.

Kamien points out that data from the HIC could be used to provide immediate information to doctors about whether a patient is a “doctor shopper”. The data are already collected and could easily be made available if the will existed. Potential prescribers could at least gain accurate and timely information on which to base their decisions. There would be less excuse for “convenience store” prescribing, and more chance of ethical behaviour. At present these data remain largely useless in preventing avoidable deaths. But, surely, learning nothing from the deaths of 202 young Australians is not an option?


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TO THE EDITOR: I write to share my concerns about the “doctor shoppers” in our community. The large medical group in which I practice has long been tormented by the demands of a constant stream of drug addicts, and I feel that we have now lost a very useful tool for dealing with these patients.

I refer to the loss of access to the “Doctor Shopping Hotline”. This has resulted in increased aggravation for both staff and doctors. The problem is compounded by our practice being open at weekends and public holidays, when these patients arrive with the familiar story of not being able to get their benzodiazepines and opiates because their own doctors are not available.
Epidemic of \(\gamma\)-hydroxybutyrate (GHB) ingestion

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**To the Editor:** The epidemic of recreational use of GHB, also known as 3-\(\eta\)-OH, is a cause for concern, as it is a basal anaesthetic agent (ie, it renders the patient unconscious, with analgesic supplementation required for surgery). It is not surprising that people taking too much of it are becoming unconscious.

GHB was introduced in France as a basal anaesthetic agent by Laborit about 1960. It has a slow onset of action (up to 10 minutes when given intravenously, thought to be due to conversion to an active metabolite, \(\gamma\)-butyrolactone). It causes bradycardia, sometimes requiring atropine administration to maintain cardiac output, and raises blood pressure. Respiration is slow and deep, so that atelectasis ventilation is not reduced.

Trials of GHB as an anaesthetic were conducted in Melbourne by Dr William Cole and myself in the late 1960s, and it was used for microlaryngeal surgery for several years. Its major problems were prolonged sleep (1–3 hours after 40–100 mg/kg in children) and a high incidence of postoperative vomiting, adding the danger of aspiration in unconscious patients.

GHB was also tried as an anaesthetic in Dunedin, New Zealand, where it was found that the sleep time could be reduced by intravenous administration of physostigmine. The fact that this drug is a basal anaesthetic needs to be more widely publicised.


Screening sigmoidoscopy for colorectal cancer

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**To the Editor:** The editorial by Viala and Olynik on screening flexible sigmoidoscopy (FS) is a welcome reminder that there are alternative colorectal neoplasia (CRN) screening strategies to the Australian National Health and Medical Research Council’s preferred option of annual faecal occult blood testing. The availability of tests for CRN screening raises the issue of whether screening tests should be dictated by government or professional bodies, or requested by the consumer. FS and colonoscopy remain potential alternatives to faecal occult blood testing in Australia, as reflected by US screening guidelines and recent local data.

However, it is unreasonable for Viala and Olynik to compare the risks of screening FS (generally diagnostic only) in average-risk subjects (perforation rate, 1/50 000) with the risks of colonoscopy (both diagnostic and therapeutic) in Western Australian tertiary hospital outpatients with symptoms or other risk factors for CRN (perforation rate 1/1000).

Firstly, it is important to recognise that the perforation risk associated with screening FS comes not just from the diagnostic screening test (1/50 000), but also from follow-up colonoscopy and subsequent polypectomy in patients with distal adenomas seen on FS.

Secondly, in the WA tertiary hospital cohort, the estimated perforation rate for diagnostic colonoscopy is about 1/2800 (and about 1/420 for colonoscopy accompanied by polypectomy). Asymptomatic subjects having screening colonoscopy are likely to have a lower risk than patients with symptoms or other significant comorbidities having investigative colonoscopy. Recent data from colonoscopic screening programs (which include subjects having polypectomy) have shown an overall perforation rate of less than 1/3000.

Medical practitioners arranging colonoscopy, and people having this procedure, should be informed about the risks involved and, importantly, be aware that these risks are likely to vary according to the setting in which colonoscopy is performed.
Algal toxins or copper poisoning — revisiting the Palm Island “epidemic”

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TO THE EDITOR: In their brief review of water and public health, Leder et al.1 uncritically attributed the Palm Island “epidemic” of 19792 to algal toxicity, commenting that it was the only recorded manifestation of this phenomenon in Australia. The original report described a hepatitis-like illness (associated in many with dehydration and bloody diarrhoea) in 138 children and 10 adults of Aboriginal and Torres Strait Islander descent living on Great Palm Island, northeast of Townsville, Queensland.3 No causative agent was actually identified.

My investigation in the early 1980s of Toxocara sp.3 was the most plausible explanation. My rationale was published as a hypothesis.3 Sadly, discretion (to protect local technicians) compelled me to withhold critical information that explained how the community had been inadvertently exposed to excessive levels of copper in its water supply. Now that water management is becoming a major societal concern and algal blooms seem to be increasing in frequency, the issue needs to be resolved — and sufficient time may have elapsed for details to be revealed without impugning individuals.

In 1985, having concluded that copper poisoning was the most likely explanation, I contacted the environmental health personnel who had overseen the mixing of algicide into the Palm Island water supply in 1979. They were aware that the actual volume of water to be treated had probably been grossly overestimated, because Solomon Dam’s water level was very low at the time. This meant that an excessive dose of copper sulfate was added to the dam, but it was assumed that this would be “erred on the safe side”. Further, the copper sulfate was not distributed uniformly through the water in the dam: a local resident with a dinghy had been contracted and instructed to spread the bags of copper salt around the dam, but had instead dumped it all at one place — immediately over the outlet pipe which carried the island’s drinking water.

This would readily explain how the community encountered a sustained pulse of high copper levels in its tap water. While chronic copper poisoning can lead to infantile hepatic cirrhosis,4 acute gastrointestinal symptoms (as manifested during the Palm Island episode) are also well documented.5,6 In the absence of laboratory confirmation of copper toxicity, the cause of the “Palm Island mystery disease” must remain speculative. However, in any future similar outbreaks, copper poisoning should be excluded before attributing the cause to algal toxicity.


LETTERS