statement of the Medical Women’s International Association (www.mwia.net), whose goals are to:

• promote the cooperation of medical women in different countries;

• actively work against gender-related inequalities in the medical profession between female and male doctors including career opportunities and economical aspects;

• offer medical women the opportunity to meet to discuss questions concerning the health and well-being of humanity; and

• overcome gender-related differences in health and health care between women and men, between girl-child and boy-child throughout the world.

The Women’s Working Party would query the ‘macho’ aspect that requires long hours of repetitive frontline clinical work without either career diversity or work-life balance. We argue that creating conditions that maximise all doctors’ inputs at all stages of their careers, including family-friendly working practices and encouraging some outside interests for all clinicians, can address both under- and over-utilisation of doctors of both sexes. The gains we can make from the entrance of women into the medical workforce are not yet all realised, and there is a need to go beyond an argument about quantity into one about quality and best use of our human resources.

The main characteristics affecting patient care are more about how an organisation and individual clinicians respond to their needs than about gender or hours worked; and a happy doctor of either sex is more likely to be effective than a disenchanted one.

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What’s in a name?

Advances in primary care chronic pain management

Over the last 20 years or so, high quality epidemiological studies have repeatedly shown that chronic pain is common and important in primary care. Up to half of the population currently has pain that has been present for at least 3 months. Studies using even the most exclusive case definitions have found that severe chronic pain is as common as ischaemic heart disease, diabetes or asthma (www.isdscotland.org). For example, high intensity, severely disabling chronic pain was found to affect more than 5% of adults. Chronic widespread pain is part of a clinically important spectrum at the far end of which is fibromyalgia, and can be defined specifically as ‘pain that is present both in two contralateral quadrants of the body and in the axial skeleton, present for at least 3 months’. The population prevalence of this is also at least 5%. These and other studies have consistently found that chronic pain is associated with poor physical, psychological and social health, and presents an enormous burden to the individual, society and the health services. Over a quarter of people with chronic pain, and half of those with severe chronic pain, have sought treatment and professional advice recently and frequently, most commonly in primary care.

The causes of chronic pain are diverse, but often remain unknown. However, many common risk factors have been identified for chronic pain of any cause, body site or diagnosis. Similarly, the impact and management needs appear to be largely

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The causes of chronic pain are diverse, but often remain unknown. However, many common risk factors have been identified for chronic pain of any cause, body site or diagnosis. Similarly, the impact and management needs appear to be largely
dependent on the severity or extent of pain, rather than on the diagnosis or body site. Despite this, a fruitless, prolonged and expensive search for a cause and cure often stands in the way of management of chronic pain and limitation of its impact. In other cases, the focus may be on treating specific diagnosed conditions (such as diabetes), at the expense of associated or underlying pain (such as diabetic neuropathy). The presence of chronic pain and the suffering it causes can therefore be overlooked by GPs and the rest of the health services.

Two papers in the Journal this month, however, will remind us, and shed some light on our approaches to management. Rohrbeck et al.4 identified a group of individuals who presented to primary care with multiple regional pain syndromes, and found that their poor health and presence of other somatic symptoms were similar to those found among patients with chronic widespread pain and fibromyalgia in other settings. They conclude that we should be more aware of the possibility of fibromyalgia and adopt general approaches to pain management, rather than treating each pain symptom separately. Their findings lead them to consider the possible benefits of applying a global chronic pain diagnosis (such as fibromyalgia) more readily than we currently do, with some research suggesting that this may allow patients and physicians to move from a cure-seeking to a rehabilitative model of management.5,9

Labels and perceptions are also important in the patient-initiated study reported from the South of England.10 Opiates are among the most ancient armaments in our pharmacopoeia, yet we have been reluctant to use them in the fight against chronic non-cancer pain. Blake et al.11 found that reasons for this reluctance may be based on false premises, including a fear of addiction and the desperation that a morphine prescription is perceived to imply. Just as importantly, however, they found that overcoming these perceptions and initiating opioid treatment can lead to dramatic improvements in the lives of people with severe, long-term non-cancer pain, when balanced carefully with adverse drug effects and appropriate warnings. This is important and topical.11

Both of these papers highlight the need for GPs to consider things that may not be immediately apparent in patients who present with a significant pain syndrome: first, that this is likely to be part of a wider, long-term serious condition with important associated health implications; and secondly that successful treatment may require drugs and communication skills that we as a profession (and therefore probably also our patients) more usually associate with treatment of terminal illness. The difference is that, while both cancer and chronic pain are often lifelong conditions, the length of life with the latter is generally longer, and the stamina required to face symptoms, use health services and address adverse reactions therefore greater, if less intense.

We must address the management of chronic pain in primary care with the same rigour as for other important chronic conditions. As Rohrbeck et al. point out, and as was recently highlighted in a report commissioned by the Scottish Executive,12 an important first step is to recognise its existence and importance, so that we can apply evidence-based approaches to treatment and prevention. There is good evidence for the effectiveness of many drugs in chronic pain conditions (www.clincalevidence.com/ceweb/conditions/msd/msd.jsp). The prescription of these according to the World Health Organisation pain ladder (www.who.int/cancer/palliative/painladder/en) is well-established in cancer pain, and may be transferable to non-cancer pain. Medication is therefore important, but insufficient by itself to manage chronic pain. Most patients obtain incomplete relief from painkillers alone, and seek other forms of treatment.13 It seems intuitive that our understanding and application of the contributing clinical, psychological and social factors should allow the development of other effective treatments. In general, however, randomised controlled trials of non-drug interventions in primary care based on these factors have found, at best, marginal benefit, or none at all. This could be because the interventions need better targeting, because they are based on relatively unimportant risk factors, or because they are in fact ineffective.13 It could also be that GPs are missing opportunities to apply effective interventions by missing, for example, important psychological factors.14

There are several areas of research here to exercise the inquiring mind with a view to developing and improving management strategies for chronic pain in primary care. Much of this is current in various locations internationally, and includes secondary subgroup analysis of existing studies to determine whether interventions of apparently limited effectiveness were more effective in specific patient subgroups; the search for new risk factors for development or persistence of pain (including biological, as well as clinical and psychosocial factors); and the continued attempt to develop and apply new interventions, or to formally test existing interventions in randomised controlled trials.15 These include cognitive behavioural therapies, physical therapies, and complementary and alternative therapies, as well as pharmacological treatments.

Several innovative models of applying traditional primary care management to chronic pain are also being introduced, with the aim of optimising the skills and opportunities that exist in this setting. These include nurse- and pharmacist-led clinics, primary care-based pain management programmes, educational initiatives for patients and professionals, and proposals in the UK for the development of GPs with a Special Interest (GPwSI) in chronic pain. Chronic pain does not exist in a vacuum, and the complexity of comorbidities and multi-dimensional treatment needs suggest that these approaches will have much to offer. Some early evaluative work suggests that these might well be effective approaches,16,17 but rigorous trials are lacking, and this area is still in its infancy. Self-management strategies are also important,18 and it is mutually beneficial to involve the patient in management decisions, as Blake et al found.11

We cannot afford to ignore chronic pain, whether we are patients, clinicians, researchers or health service managers. With primary care at the forefront, there are many possible approaches to its management on the horizon. These will depend upon the arrival of evidence and resources. Meanwhile, however, we are reminded by the papers in this Journal that there is much we can do at a fundamental level to improve the lives of our patients with chronic pain.
The new tuberculosis

Raised awareness of tuberculosis is vital in general practice

Thirty years ago epidemiologists confidently predicted that tuberculosis (TB), like smallpox, would soon be eradicated. But TB is resurgent in places as diverse as sub-Saharan Africa, European cities, the former Soviet Union, central Asia and south America.1,2 New York’s TB epidemic of the 1990s cost £625m to control.3 The World Health Organisation declared TB a global emergency in 1992.4 Multidrug resistant (MDR-TB)5 and rapidly fatal extremely drug resistant (XDR-TB) strains have made newspaper headlines. This re-emergence has rightly been dubbed ‘the new TB’.6

Infectious diseases thrive in times of social and environmental upheaval — TB reached its (initial) peak during the industrial revolution. We have just completed the most barbaric century in recorded history;7 human migration is unprecedented;8 and climate change is a reality. Several factors are catalysing the re-emergence of TB: first, the advent of HIV,9 coupled with the huge reservoir of latent TB infection (one-third of the world is estimated to be infected); second, rising levels of multiple drug resistance, stemming from inconsistent antibiotic use and treatment non-compliance; and third, disruption arising from conflicts, widening social inequalities and disrupted health systems.

The rise of TB in the UK continues: the annual UK figures from the Health Protection Agency show an 11% increase in cases for 2005 with the majority of the 8113 total occurring in young adults (61% between ages 15–44 years) and in the non-UK born population (72%).10 Notification rates of TB in east London have exceeded 100/100 000 population which is approaching the average for India as a whole.11 Nine per cent of UK cases are resistant to at least one first-line drug. Treatment completion rates at 79% are below the 85% target in the Chief Medical Officer’s Action Plan.12 Death is the commonest reason for not completing treatment in patients aged over 45 years, notably among white UK-born men.13 The NHS has recently focused efforts on improving chronic disease management, but these data, and other problem infectious diseases — HIV, hepatitis C, sexually transmitted diseases — suggest they are ignored at our peril.

To stereotype TB as a disease of foreign-born people is unwise and clinically inaccurate. TB remains first a disease linked to poverty and social exclusion.14 North east London’s ongoing outbreak of isoniazid-resistant TB has reached 292 cases, is the largest in Europe, and is focused on prisoners and crack cocaine abusers rather than a specific ethnic minority group (G Bothamley, personal communication, 2007). That two-thirds of TB cases occur in people born abroad suggests that migration is a factor, but to say that migrants bring TB to the UK is an oversimplification. In eight out of 10 cases active TB is diagnosed 2 years or more after their arrival in the UK, suggesting that factors related to migration predispose to reactivation of latent TB infection.15 These might be nutritional, stress-related or environmental, such as suboptimal housing or overcrowding once in the UK. Interestingly, vitamin D levels fall after migration to the UK and vitamin D deficiency is an independent risk factor for TB.16 Vitamin D was used as a treatment in the pre-antibiotic era (as was sunbathing or ‘heliotherapy’)17,18 and recent data show the vitamin induces innate immunity to Mycobacterium tuberculosis.19

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