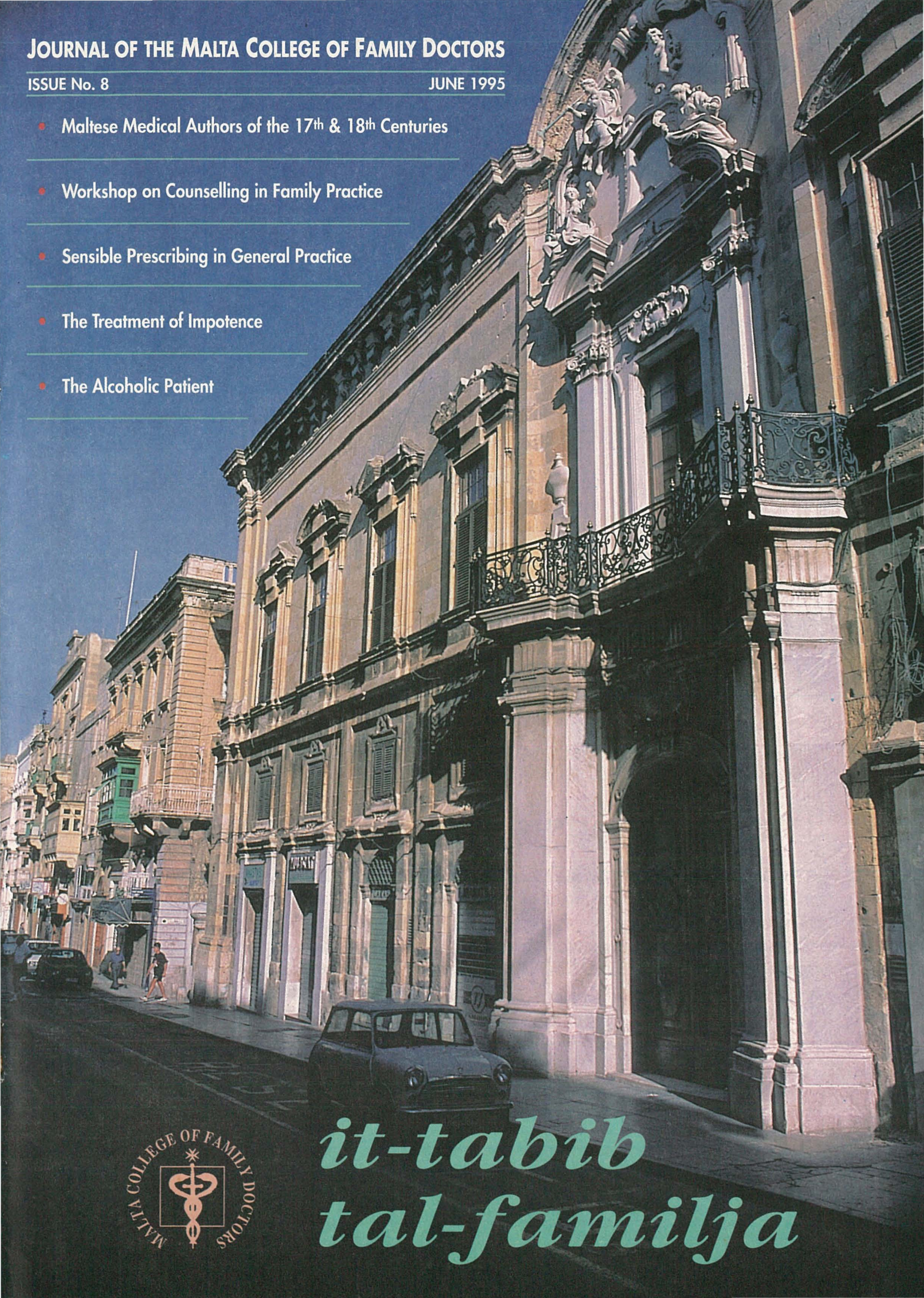
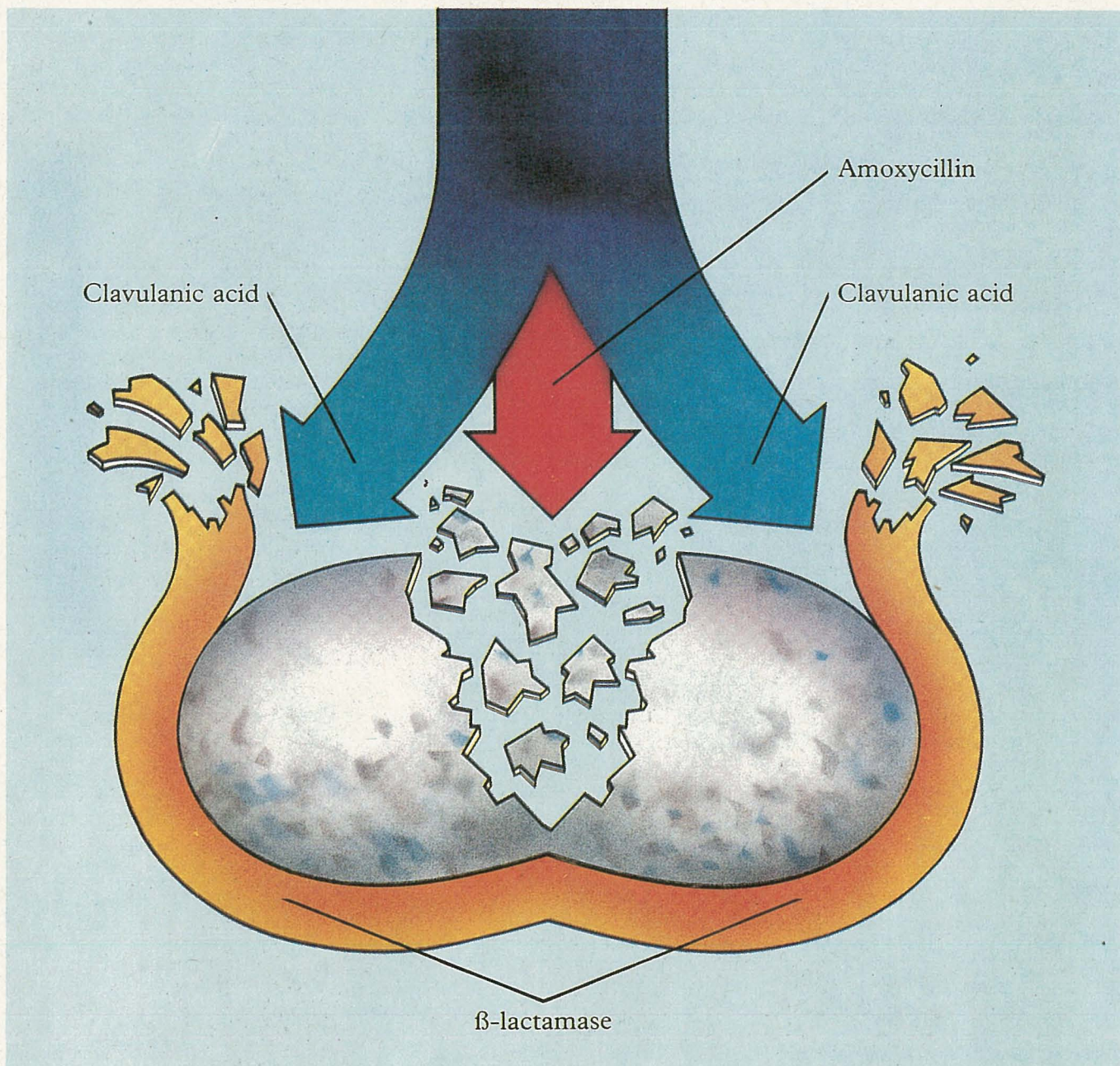


- Maltese Medical Authors of the 17th & 18th Centuries
- Workshop on Counselling in Family Practice
- Sensible Prescribing in General Practice
- The Treatment of Impotence
- The Alcoholic Patient



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3. Focht J, et al. *Chemother* 1988; 34(4): 332. 4. Lim BT, et al. *J Drug Dev* 1989; 2(Suppl 1): 15. 5. Finch R. *Med Int* 1988; 52: 2146.
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Editorial

Dear Readers,

May I welcome you to the first issue of 1995. You will have immediately noticed the new front cover design and the change to full colour. What you may not have noticed is that the journal is now printed on recycled paper. Thanks go to BUPA, Lombard Bank and the Medical Protection Society, who have continued to support our efforts, and without whose help these improvements could not have materialised.

I like to think that these changes reflect the modern approach and readiness to change of our college. Many new developments are taking place at this time, and the future looks bright for our college and its members. Dr. Tony Mifsud attended the European General Practice Research Workshop in Porto, Portugal in May and has received confirmation of the Malta meeting in October 1996. The college has arranged sponsorship for the event, and members are invited to participate in the workshop and present papers or research work. The college sub-committee on specialist training has compiled a directory of Family Doctors, and is reading published material relative to specialist training with a view of setting up such a course here in Malta. The college is also liaising with the Malta Chamber of Pharmacists regarding areas of common interest and will be organising a symposium in the future.

Many other projects are still in their infancy, and much work remains to be done. Any members who think that they may help out or make useful contributions to the work of the council are invited to write to our secretary. Offers to write articles for the journal or present papers at our CPD meetings are always most welcome. Thank you.

Jean Karl Soler

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Cover Photo taken by J.K. Soler: *The Castellania Palace, today the seat of the Parliamentary Secretary for Health and of the Public Health Department, originally housed the Law Courts of Valletta. As the edifice now appears goes back to 1758. It derives its name from the Castellano who was a Knight of the Order of St. John with the function of seeing that justice was rightly administered for everyone. The building became the head office of the Public Health Department in 1896. It is famous for its old laboratory where Sir Themistocles Zammit discovered the Brucella Melitensis in the blood of the goat in 1905.*

Introduction

Dr. Farrugia was my predecessor as editor of this journal and Secretary for Information on the College council, until he was elected Mayor of Zebbug and felt the pressures of office. He has contributed a lot of time and effort to College activities, and continues to run a busy family practice in his home town. This paper was presented as a "How I manage" talk at one of our CPDs. – The Editor

In this presentation, I will share my personal views on the treatment of the sexual disorder, impotence.

Introduction

As some of my colleagues did, you may wonder why did I choose such a topic? I feel that in Malta it is high time that the medical profession takes a more professional approach to sexual disturbances. Malta lacks the facilities of specialised centres or of a sexologist. The undergraduate medical curriculum may speak for itself, in that it never tackled sexual disorders with orientation towards medical treatment. I would like to make a few general comments.

The approach to the sexual complaint is frequently awkwardly handled by the physician, and by the patient. The patient may be inhibited from describing important sexual problems through shyness, embarrassment, guilt or feelings of inadequacy. On the other hand, the doctor may feel uncomfortable, may disapprove or may fail to ask the right questions.

The present day openness about sexuality in the media does not necessarily mean that individual patients are better educated regarding sexual matters, nor more willing to initiate discussion of sexual complaints. In this respect I also believe that locally, doctors rarely inquire about this health problem during their history taking.

Sexuality is part of our promotive health care, and we are in duty to educate our patients.

Sexual complaints call for strict confidentiality and trust. Due to a more developed doctor-patient relationship at the level of the family doctor, this is a more common presenting complaint at the primary rather than secondary care level. Usually such a patient attends the clinic unaccompanied, and comes up with the problem only after having raised other minor problems as a preamble.

Our general approach must be one which respects the patient's dignity. History taking should make use of only scientific terminology when referring to sexual activities and organs. A hurried approach to such problems may evoke a hostile response, especially if a psychiatric referral is discussed. Tact is required, even in a busy clinic. Referral should be tailored to the nature of the problem and to the life style and personality of the patient. Some patients prefer to discuss intimate details of a sexual problem with you, their own family doctor.

On the other hand, many patients want a quick remedy which, unfortunately, we cannot provide. Comprehensive programmes, such as described by Masters and Johnson are not readily accepted. Counselling is a therapeutic tool in this health problem, as in many others. If the family doctor is in difficulty to

provide this, he must still make every effort to keep in touch with the patient. The evaluation of the efficacy of the treatment programme, and the provision of support and a reassuring attitude is vital in the management of sexual disorders. The sexual problems of the elderly and of homosexuals are not well understood and are overlooked by many doctors. These two categories of patients need more attention.

Clinical Presentation

At this point I wish to discuss this clinical presentation.

A single 37 year old male presents at the clinic complaining of erectile impotence in the presence of his partner. He feels helpless and is frustrated, as this problem has been increasing over the last three months. He gives a past history of high cholesterol and a family history of diabetes. He has social discord and occasionally abuses of alcohol. He has also noticed two penile warts.

Male sexual dysfunction, often termed impotence, may manifest in different ways: loss of desire, inability to achieve or maintain erection, premature ejaculation, absence of emission and inability to achieve orgasm. These complaints may be secondary to other chronic disorders, for example of the urogenital or

endocrine systems, or the result of psychological or psychiatric disturbance, or both.

The case history describes a young adult who has developed impotence gradually, progressing from intermittent failure to inability to sustain an erection in the presence of his partner, and consequent failure to complete intercourse.

The central issue in the evaluation of impotence is to separate instances due to psychological factors from those due to organic causes, and this distinction can be made on the basis of the history.

History-taking

Psychogenic impotence occurs in a setting of stress, which may be social, economic or occupational. The symptoms may start against a background of depression or anxiety. This disorder results in a complex interaction between physical, emotional and social health, and this symptom has to be evaluated in the context of the relationship between the patient and his partner/partners. One must inquire about factors such as disinterest in the sexual partner, fear of sexual incompetence, or deviant sexual attitudes. An understanding of the patient's lifestyle and daily habits may provide clues to the diagnosis. One must establish the health status of the partner. Fatigue, anxiety, stress, accidents, surgical procedures, bereavement, etc. may affect sexual behaviour acutely or chronically.

Typically, sufferers have good erections in private and during sleep, and may masturbate, but cannot perform in the company of their partners. Nocturnal erection or nocturnal penile tumescence (N.P.T.) occurs during REM sleep, and averages 100 minutes per night. If N.P.T. can be confirmed from the history, the dysfunction is probably psychogenic.

Organic impotence correlates with increasing age and is slow to develop. The causes may be

- **endocrine**, such as testicular failure or hyperprolactinaemia
- due to **drugs** such as anti-histamines, antihypertensives, tranquillisers, alcohol and illicit drugs such as heroin
- **neurological** such as diabetes mellitus, pelvic surgery, anterior temporal lobe lesions, or tumours and lesions of the spinal cord
- **vascular** disease includes Leriche syndrome
- **penile trauma**
- **Peyronie's disease**
- previous priapism

The case history under study seems to be more probably a case of impotence due to psychological problems.

The physical examination

Although the history is indicative of a psychogenic cause for impotence, the patient may be reluctant to accept reassurances without a thorough physical examination and investigation.

One must pay particular attention to the vascular and neurologic status of the lower limbs. The peripheral pulses and the penile pulse are palpated, but the absence of the latter in the flaccid state is not clinically significant. Neurological examination of the lower limbs, with assessment of muscle power, sensation to various modalities including vibration, and reflexes is carried out. One tests sensation in the perineal region, anal sphincter tone, and the bulbo-cavernous reflex.

In the examination of the genitalia, one looks at the size and consistency of the testes. Softening and atrophy suggest a primary testicular disorder, and

this is usually accompanied by profound changes of body habitus with loss of secondary sexual characteristics. The penis is examined for indurations or plaques, found in Peyronie's disease, and for gross anatomical malformations which the patient may be unaware of or conceal. Occasionally patients may have misconceptions or feelings of shame about their bodies, and should be reassured during this part of the examination. Two warts are noted in this particular case, but the rest of the examination is unremarkable.

Investigations

Measurement of serum testosterone in the absence of feminization or hypogonadism is seldom helpful. However, the serum prolactin level and blood glucose are mandatory. If the history denotes occasional alcohol excess a serum gamma-GT is helpful, as liver disease is unlikely with a normal level. Rarely, hypothyroidism causes impotence, but this is worth considering in elder males.

Our patient suffers from hypercholesterolaemia. This is a cardiovascular risk factor, and should be investigated as part of our screening of male patients, who tend to consult their family doctor rather less frequently. If there is an indication in the history or examination that a vascular cause is likely, the patient should be referred to a specialist for Doppler studies or arteriography.

A new diagnostic clinical test, which is also useful for treatment and is easily performed in the clinic by the family doctor, involves the intra-cavernosal injection of prostaglandin E₁. The doctor injects a 5µg dose of PGE₁ using an insulin syringe into the lateral aspect of the shaft of the penis at the 2 o'clock or 11 o'clock position. A good response to the 5µg dose indicates good function of the organ, and suggests a neurogenic or psychogenic cause

for impotence. Higher doses, up to 60µg, suggest other organic causes. This test is not in common usage. PE₁ is a safe and effective drug, but is stable only at 4° C.

Specialised centres may also make use of N.P.T. measurements through the use of computerised electronic tests, and dynamic stress tests to measure blood flow. Discussion of these tests is beyond the scope of this paper.

Treatment

In my limited personal experience as a family doctor, some sexual problems resolve spontaneously during the evaluation process. Referral is usually difficult for the patient, because it implies a transition to the care of another physician after having confided an intimate health problem with his family doctor. An eager patient may lose motivation if referred elsewhere. Referral depends on the genuine interest of the family doctor in tackling impotence, on the doctor-patient relationship, and on the aetiology of causative medical illness. In the evaluation and follow up appointments, the doctor must ensure that he has enough time to listen attentively and if need be counsel the patient.

Personally speaking, I believe that this case presentation may be adequately managed by a family doctor, as it manifests as a reactive psychogenic disorder amenable to counselling as therapy. If the patient had more deep-seated problems, he might be better managed by a specialist such as a psychiatrist. As an adjunct to therapy, I will prescribe a short-acting anxiolytic, preferably a non-addictive one that does not require a control card. Anti-depressants such as the newer RIMA (reversible inhibitor of MAO A type) or SSRI (selective serotonin re-uptake inhibitor) types may be prescribed if necessary.

Medical therapy with androgens offers little more than placebo effect except in cases of hypogonadism. If blood tests reveal a prolactin secreting pituitary tumour, surgical removal or bromocriptine therapy usually results in return of potency.

The opportunity to educate this sexually active patient should not be missed. Questions should be discreet and non-judgmental. Sexually transmitted diseases in general should be discussed, and preventive measures highlighted.

His verrucae need cautery, and this may be performed easily at the clinic.

This case does not require surgical intervention. However, other cases due to aortic obstruction or priapism may be cured by such surgical procedures as end-arterectomy and shunting of the corpora spongiosa, respectively.

In refractory cases, self-injection with PGE₁ is ideal. This is not without its side effects. If the patient is diabetic and the cause is diabetic neuropathy, one may consider surgical implantation of a penile prosthesis. The silastic rod only prevents buckling during intercourse, but inflatable prosthetic devices exist that simulate an erection.

Conclusion

In this presentation I have tried to describe the management of a health problem that requires not only clinical skills, but also one must rely heavily on interpersonal relationship with the patient in diagnosis and management. As well as discussing my personal views and how I would manage this case, I have highlighted problems and lack of local facilities in dealing with such cases, whilst explaining the various modes of therapy.

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The Health and Safety at Work Act 1992 came into effect on 1 January 1993, and as it applies to all work situations where five or more people are employed, it is of great importance to most general practices. Heavy fines are payable for failure to comply.

The Health and Safety Commission (HSC) and Health and Safety Executive (HSE) have produced guidance on the Regulations, but this new publication from the RCGP is the first to provide guidance on the requirements of the Health and Safety Act as it applies to general practice. It has been produced by combining and updating two documents: one by Dr Stephen Moore on behalf of the Leicestershire FHSA, the other by Dr Richard Moore on behalf of the Shropshire MAAG.

This book, the first of a new series of books on practice organisation, not only describes the responsibilities of the general practitioner employer and particular hazards to watch for, but suggests a plan for implementation, review and audit. Useful factsheets, protocols and audit forms are included as useful starting points for practices to devise their own.

Health and Safety at Work, Practice Organisation Series No. 1 is available from RCGP Sales price £15.00 (£16.50 non-members) including postage. Access and Visa are welcome, 24 hours. Tel: 0171 225 3048.

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INFLUENCES ON COMPUTER USE IN GENERAL PRACTICE

OCCASIONAL PAPER 68

Computerisation has been one of the unsung triumphs of British general practice. By the early 1990s general practitioners were ahead of their colleagues in hospital medicine in adopting their use and ahead of general practitioners in most other countries of the world.

About nine-tenths of general practitioners were using the computer in some way by 1993, but little has been known about those practices who do not use computers. This new *Occasional Paper* by Professor Michael Pringle and colleagues is therefore particularly welcome because it is the biggest survey so far studying the reasons why general practitioners, particularly in inner cities, do *not* use computers or use them less often than colleagues in other areas.

The authors identified 1131 inner city practices in six FHSAs (representing 11% of all English general practices) and obtained a 61% response rate to their questionnaire. They found "strong and systematic associations" between a common pattern of practice delivery in those practices which are computerised, compared with those that are not. This is contrary to what had previously been assumed and suggests that the presence of a computer may well be an indicator of practice development and quality of care regardless of the uses to which it is put.

This work represents the state of the art on the use of computers in general practice with particular reference to those practices that have not adopted them. It should therefore become a valuable reference on this subject.

Influences on Computer Use in General Practice, Occasional Paper 68 is available from RCGP Sales, price £15.00 (£16.50 non-members) including postage. Access and Visa are welcome, 24 hours. Tel: 0171 225 3048.

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EUROPEAN GENERAL PRACTICE RESEARCH WORKSHOP – 3RD TO 6TH OCTOBER 1996

Notice is given of the European General Practice Research Workshop in Malta to be held at the New Dolmen Hotel in Qawra. The meetings to be held in the morning on Friday the 4th, Saturday the 5th and Sunday the 6th are open to local participants, and will be accredited by the college. The workshop is expected to be well attended, with participants from all over Europe, and is a forum for discussion of research topics and papers related to the central theme, which is to be announced shortly. Interested parties are invited to write to the editor for further details, and will be sent a copy of the call for papers when this is published.

The European General Practice Research Workshop will meet twice before the Malta meeting, namely in Ireland in October 1995 and in Sweden in May 1996. A trainers course will be held in Ireland one week after the workshop. Please write to the editor for further details.

The National Library of Malta holds a number of books by Maltese medical authors of the 17th and 18th centuries. These books present various aspects of the theories and exercise of medicine and surgery and of areas of "specialization" of those days.

Twenty-seven publications have been traced and are here surveyed. A number of unpublished medical manuscripts are also extant (such as those of the surgeon Michel'Angelo Grima and physician Giuseppe De Marco) but these have not been included in this paper which is intended to illustrate printed works only.

The books have been grouped in accordance with their subject matter and listed by the year of publication:

<i>Surgery</i>	9
<i>Physiology</i>	8
<i>Anatomy</i>	3
<i>Plague</i>	2
<i>Psychiatry</i>	2
<i>Medicine</i>	1
<i>Dentistry</i>	1
<i>Sexually transmitted diseases</i>	1

Of these works only seven were printed and published in Malta. The remaining twenty books were published abroad i.e. ten in Italy and Sicily; nine in France; and one in London. Malta was then ruled by the Chivalric Order of St. John of Jerusalem whose knights came mainly from France and Italy. It was, therefore, inevitable that Maltese medicine and surgery reflected the influence of medical developments in France and Italy; hence the reason why so many of the books were published in these two countries.

Latin was at that time the language of learned men; it is not surprising, therefore, that sixteen of the books were written in Latin to be followed by nine in Italian and two in French.

Surgery

Maurin, J.F. *Dissertatio Chirurgica Medico-Practica de Vulneribus*, Monspelii, 1745, 70 pp.

Dr. Joannes-Franciscus Maurin was of French ancestry, his family having settled in Malta in 1619. He studied in Montpellier. In this work he describes the different types of wounds and the tissues involved (skin, muscles, ligaments, et). He gives special consideration to penetrating wounds of the cavities of the thorax and abdomen; and to lesions of the various organs and blood vessels that may be involved as well as depressed fractures of the skull. Diagnosis and prognosis are discussed.

Henin, G. *Observatio chirurgico-anatomica*, Messina, 1749, 12pp.

This is the case of a "sarcoma" of the back which Henin removed surgically with the survival of the patient who had come to Malta from Messina to consult the surgeons of the Holy Infirmary about the growth.

Valletta born Gabriel Henin (1696-1754) held the Chair of Anatomy and Surgery at the Holy Infirmary of Valletta. Besides being the Chief Surgeon at this hospital, he was also an oculist and an operator for the removal of stones from the urinary bladder.

Grima, M.A. *Delle osservazioni fatte sopra il corpo vivente d'alcuni animali intorno le ferite penetranti la gran cavità dell'addome. Novelle Letterarie*, No, 29, Firenze, 1754.

In this study Grima describes the experiments carried out by him on living dogs while he was studying surgery in Florence. He showed that surgical removal of the spleen did not cause death and that such an operation was feasible also on human beings when the spleen was injured or diseased. He suggested the term "splenotomy" for the operation.

Michel'Angelo Grima (c. 1731-1798) studied surgery at the Holy Infirmary of Valletta and then at the hospital of *Santa Maria Nuova* of Florence. In 1754 he obtained the doctorate in philosophy and medicine of the University of Pisa and in 1758 was approved as surgeon by the *Collegio dell'Arte Medica* of Florence. In the following year he went to Paris for further studies and joined the French Army as a surgeon during the Seven Years War serving in a hospital at Cassel. He returned to Malta in 1763, was appointed Senior Surgeon and Lecturer in Anatomy and Surgery at the School of the Holy Infirmary. He is the author of at least fifteen published and manuscript works. He retired from the lectureship and the hospital service in 1797.

Grima, M.A. *Del nuovo e sicuro metodo di cucire gl'intestina*, Parigi, 1760, 30 pp.

Grima describes the operation proposed by him for the surgical treatment of lacerations of the intestine. It consisted in cutting away the injured loops of the

intestine and re-uniting the healthy portions in an end-to-end union by means of a spiral suture. He had experimented successfully with this type of suture on living dogs.

Grima, M.A. *Riflessioni del Sig. Michel'Angelo Grima sopra il Taglio laterale che per estrarre la pietra della vesica orinario pratica il Signor Guglielmo Bromfeild* **Giornale Francese di Medicina, Chirurgia e Farmacia**, Firenze, Feb. 1761.

This is a detailed description of the operation performed by Grima on the cadaver with the "double gorgeret" – an instrument invented by William Bromfeild senior (1713-92) for the extraction of stones from the urinary bladder through the lateral approach. He concludes that the Bromfeild's instrument and technique represented an advance over William Cheselden's (1688-1752) method and instrument.

Grima, M.A. *Reflexions sur le memoire sur la taille laterale de M. Bromfield (sic)*. **Journal de Med. Chir. et Pharm.** 1761, Vol. XIV, p. 161.

This is the French rendering of the Italian *Riflessioni* (q.v.).

Azzopardi, G. & Bruno, G. *Lettera apologetica contro la dissertazione intitolata 'Nuovo e sicuro metodo di cucire gl'intestini'*, Messina, 1762, 29 pp.

This work is a critical review of Grima's book written by his contemporaries and rivals Dr. Gaetano Azzopardi and Giovanni Bruno, the former being a retired Principal Physician and the latter occupying the same post on the staff of the Holy Infirmary.

The authors argued that Grima was not the originator of the spiral suture of the intestines as this method of stitching had been used by surgeons prior to him.

Dr Azzopardi studied in Malta and then spent four years at Montpellier in the pursuit of the theory and practice of medicine before becoming Principal Physician.

Grima, M.A. *De poplitis aneurismata dissertatio*. Londini, 1773, 16, pp.

Grima discusses the causes, manifestations, classification and treatment of aneurysms of the popliteal artery. It is the result of his observations and experiences during his stay at the Hospital of Santa Maria Nuova at Florence. Though, according to the title-page, the book was published in London no evidence has so far been forthcoming that Grima ever went to Great Britain though he had expressed the wish to be granted a bursary by the Order of St. John to enable him to spend two years in England to enrich his surgical experience.

Grima, M.A. *Della medicina traumatica*, Firenze, 1773, 240 pp.

This treatise deals with the surgical management of fire-arm wounds of twenty-four soldiers under his care at the hospital of Cassel while he was in the service of the French Army during the Seven Years War (1756-63). Grima published this book for the benefit of his students as he held the view that war was "the great school not only of traumatic medicine (surgery) but of the whole of medicine".

Physiology

De Marco, G. *Dissertatio physiologica de respirazione ejusque usu primario*, Monspeli, 1744. 83 pp.

After studying in Malta, Dr. Giuseppe De Marco (1712-1789) went to widen his medical knowledge and experience at Montpellier in 1741. The above *Dissertatio* is the text of his thesis

presented and accepted for his doctorate. It deals with the functions of respiration.

Locano, G.J.B. *Dissertatio physiologica de mechanico feminarum tributo*, Monspeli, 1749, 43 pp.

Dr. Giorgio J.B. Locano studied medicine at Montpellier obtaining the doctorate of that university in 1749 in which year he published this short treatise on the anatomy and physiology of the female reproductive system with special reference to menstruation.

On returning to Malta he spent some time as physician in the navy of the Order of St. John (1754) and was later appointed physician to the Women's Hospital and District Medical Officer of Valletta. He also occupied the Chair of Medicine at our University.

De Marco, C. *De lanarite in secunda, et adversa valetudine adhibenda*, Malta, 1759, 367 pp.

The author discusses the effects of wearing woollen clothing in health and in illness.

The copy at the National Malta Library bears the certificates of the *Censor Librorum* and approval of the three authorities that controlled the publication and printing of books in the Maltese Islands in the 18th century – the State, the Bishop and the Inquisitor. The title page is marked with the stamp of the Holy Office of the Inquisition of Malta.

De Marco, G. *Dissertatio de cocholata*, Malta, 1760, 28 pp.

The use and abuse of the drinking of chocolate forms the subject of this booklet. The author also discusses whether the consumption of draughts of chocolate breaks the ecclesiastical fasting.

JOSEPHI DEMARCO

Medici Melitensis Philosophiæ, & Universitatis Monspelliensis

MEDICINÆ DOCTORIS

DE LANA

Ritè in Secunda, & Adversâ valetudine adhibenda.

OPUS, QUO

Villoz Vestis nudi contactus Præstantia, & Actio Staticæ experimentis per-
spicue, Utilitates fusè demonstrantur, Noxæ diligenter expenduntur.

Adjecta est ad calcem

DISSERTATIO DE USU, ET ABUSU CHOCOLATÆ

In Re Medica, & Morali.



MELITÆ in Palatio, & ex Typographia C. S. S. MDCCLXXI.
Apud D. Nicolaum Capacium ejus Typographum. X Superior. Sacrat.

Title page of Dr. Jos. Demarco's treatise *De Lana* and his dissertation on the use and abuse of chocolate drinking. It was published in Malta and bears the stamp of the Holy Office of the Inquisition.

Grima, M.A. *Memoire sur la sensibilitè des tendons.* Paris, 1760, 29 pp.

Grima describes several experiments of a physiological kind carried out by him on living animals, among which three dogs, to show that tendons are sensitive to painful stimuli. The experiments were performed in 1755 during his stay at Florence. He also reports the case of a patient whose tendons of his right big toe had become exposed through disease and who felt pain when these tendons were touched with a forceps.

Locano, J.G.B. *De imperio muscolorum in oeconomia animali,* Malta, 1774, 18 pp.

In this treatise the author describes the functions of the muscular bundles of the body.

Grima, M.A. *Della sensibilità dei tendini con l'aggiunta di altre lettere sopra il medesimo argomento di altri autori,* Venezia, 1776, pp.

This publication is the Italian rendering of Grima's French *Memoire sur la sensibilitè des tendons* of 1760 (q.v.).

It is dedicated to the Bailiff Clemente Resseguier who had founded a lectureship in Surgery at the Holy Infirmary of Valletta in 1775 with M.A. Grima as its holder. The *lettere* are laudatory comments from Monsieur Le Cat, *Primo Professore della Francia*, and from Giambattista Franchi, *Primo Professore d'Anatomia in Torino*.

Locano, J.G.B. *De imperio gangliorum in oeconomia animali,* Malta, 1776, 23 pp.

This treatise deals with the anatomy and integrative function of the nervous system. Locano refers to the works of the leading and influential anatomists and physicians of the 17th and 18th centuries.

Anatomy

Locano, G.J.B. *De novo spinalis medulla ductu,* Malta, 1761, 140 pp.

The writer reviews the opinions expressed by various medical authors about the anatomy of the spinal medulla and the base of the brain. He reports the finding of a polyp at the base of the brain during the post mortem examination of a woman who died in the Women's Hospital at Valletta on April 11, 1758.

The bibliography that he cites shows that Locano was a man of great erudition with a wide knowledge of the foremost anatomical literature of his time. Among the authors that he refers to are Albrecht von Haller (1708-77), Hermann Boerhaave (1668-1738), Bartolomeus Eustachius (1520-1574) and Gabriel Fallopius (1523-1562).

Grima, M.A. *Due relazioni medico-anatomiche,* Malta, 1764, 12 pp.

Grima reports the findings in two necropsies carried out on two ladies of the Florentine aristocracy in 1756 and 1757. In the first case there was an abscess of the left ovary; in the second instance there was an abscess in the right iliac fossa involving the bowels. This is the only work of Grima to be published in Malta.

Grima, M.A. *Instituzioni d'anatomia,* Venice, 1781, 426 pp.

This book consists of the lectures delivered by Grima to his students at the Holy Infirmary of Valletta. Following a brief historical account of the teaching of anatomy in Europe and in Malta, he describes in detail the

bones, ligaments and joints of the human body. His lectures on the muscles, arteries, veins and nerves have survived in a manuscript which appears to consist of the notes written by a surgical student in 1785.

Plague

Axiaq, L. *De postrema melitensi lue praxis historica*, Palermo, 1677, 101 pp.

Dr. L. Axiaq lived throughout the plague epidemic of 1675-76. He has recorded the clinical manifestations of the disease in the bubonic and pulmonary forms. With regard to the latter form of the illness he was remarkably close to the aetiological truth as we know it today when he stated that the *semina* of the disease entered the human body through the respiratory system in the pneumonic type.

Cavallini, Ph. *Melita liberata a peste*, Rome, 1690, 42 pp.

Philippus Cavallini was a physician in the service of the Order of St. John at the time of the plague of 1675-76. It is not known whether he was Maltese though he calls himself a *medicus Melitensis* in this book. However that may be, he has recorded and edited in this book the correspondence, about the nature of the epidemic, of a Maltese physician, Dr. G. Francesco Bonamico (1639-80), exchanged with the medical academies of Paris, Florence, Pisa, Rome and Valencia in which he described the manifestations of the epidemic which he rightly diagnosed as plague against those who maintained that the illness had no pestilential characters but was simply a "malignant fever".

The copy at the National Malta Library belonged, at different times, to Fra Giuseppe Zammit, Director of the School of Anatomy and Surgery at the Holy Infirmary of Valletta; the Rev. Ignazio Saverio Mifsud, a cultured man; and to another owner whose name has been scribbled over and is illegible.

Psychiatry

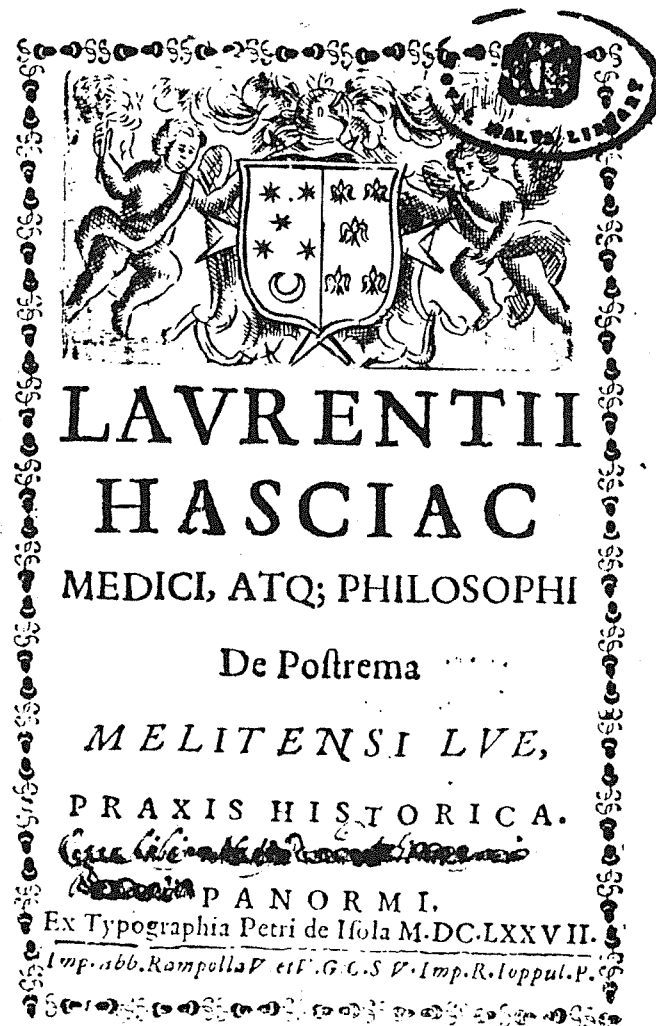
Imbert, G. *Questio medica eaque therapeutica an aegrotantes imaginarii sola diversitate idearum rejecto omni rimediorum apparatu sanandi sint*, Monspeli, 1723, 67 pp.

Dr. George Imbert (1702-1786) dedicated this treatise on melancholia (depression) to Grand Master Fra Antonio Manoel de Vilhena. The author describes the physical and mental symptomatology of depression and discusses its diagnosis and treatment. Among the remedial measures he advocated was participation by the patient in conversations with friends and in festivals and listening to vocal and instrumental music.

Dr. Imbert had a full medical career rising eventually to the rank of *Protomedicus* of the Order of St. John – a post equivalent to that of Chief Government Medical Officer of to-day.

Bernard, S. *Trattato filosofico-medico dell'uomo e sue principali operazioni*, Catania, 1749, 111 pp.

According to Dr. Salvatore Bernard's concept of the nervous system, the functions of the brain were mediated by the "animal spirits" which reached this organ by means of the nerves which were believed to be hollow tubes. Acute mental disorder was attributed to a commotion of these "animal spirits". He recognised the power of suggestion on human behaviour. In fact he ascribed the unexpected cures from certain diseases, which had not responded



Title page of Lorenzo Hasciac (Axaq)'s account of the plague of 1675-76. Published in Palermo in 1677.

TRATTATO FILOSOFICO MEDICO

Dell' Uomo, e sue principali Operazioni.

OPERA
DI SALVATORE

BERNARD

Medico Maltese,

Dedicata

ALL' ALTEZZA EMINENTISSIMA

DEL SIGNORE FR.

D. EMMANUELE

PINTO

DEGNISSIMO GRAN MAESTRO,

E

Principe di Malta, e Gozo, &c.

In Catania nel Palazzo dell' Illustrissimo Senato, nella
Stamperia del Dottor Bisagni 1749.) (*Con lic. de' Sup*

Title page of Dr. S. Bernard's work on the functions of the nervous system published at Catania in 1749.

to various kinds of treatment, to suggestion.

Dr. Bernard (1724-1806) studied medicine at the University of Aix-en-Provence graduating in 1749. He occupied the post of physician at Santo Spirito Hospital at Rabat and later on at the Lazzaretto.

Medicine

De Marco, G. *Tractatus mechanicus de non-naturalibus*, Avenione, 1748, 402 pp.

The author considers the clinical features of various diseases with emphasis on asthma, consumption and ascites. From his references to such brilliant clinicians as Thomas Sydenham (1624-89), Giorgio Baglivi (1668-1706), Archibald Pitcairne (1652-1713) and Richard Mead (1673-1754) he shows that he was well versed with contemporary medical literature.

Dentistry

Cossaeus, J. *Suprema apollinaris laurea seu doctoratus questiones quatuor cardinales*, Monspelli, 1636, 13 pp.

The "Third Question" entitled *An odontalgiae nevrotomia?* is the earliest known publication on dentistry by a medical man who calls himself a *Melitensis Artium Magister et Licentiatu Medicinæ* but about whose nationality there are doubts. Is *Cossaeus* the Latin rendering of Cossai or Cassia or Casha?

The treatment he recommends for dental pain is the surgical section of the nerve "which runs to the teeth through the auditory meatus". The cut was to be made in "the internal and lower part of the ear".

The other questions deal with the superstitious belief in the casting of spells; the need for sexual expression to ensure a healthy life; and whether the medicaments in use in his time were as efficacious as in earlier times.

The work is dedicated to Grand Master Jean Paul Lascaris.

Cossaeus is the author of five other *Quaestiones* which he submitted and defended to obtain his doctorate of the University of Montpellier in 1636 and 1637. They deal with:

- (a) The use of onions for the relief of pain caused by obstructive renal and vesical calculi.
- (b) Treatment by venesection to alleviate the eruption of skin bleedings and to "cool" the blood when its temperature rises.
- (c) The benefit derived from luke warm baths in cases of jaundice.
- (d) The administration of aloe pills in migraine.

- (e) The evidence that uterine moles are the result of the fecundation of the ova by semen.

Sexually Transmitted Diseases

Cren, F.A. *Tractatus physico-medicus de Americana lue*, Malta, 1762, 207 pp.

Dr. Fortunato Antonio Cren (or Creni) discusses the origin of syphilis or the "American disease" so called according to the view that it was brought to Naples from the West Indies by the sailors of Christopher Columbus in 1492.

The author describes the signs and symptoms and means of propagation of the disease. He condemned the use of crude mercury in its treatment because of the toxicity of this metal.

Dr. Cren's publication elicited a critical *Responsio* or reply by an unnamed writer published in Catania in 1764 (*Responsio ad epistolam in tractatu physico-medico Doctoris Fortunati Antonii Cren editam*, 13 pp).

Comment

These medical publications represent the "highlights" of the knowledge of the "science" and of the exercise of the healing art of the 17th and 18th centuries as expressed by Maltese physicians and surgeons of those periods.

A perusal of their works shows that, in comparison with the medical professionals of to-day, they had less demands on their skills; and a narrower range of responsibilities was laid on their diagnostic acumen and therapeutic interventions. However, the fact that their concepts and remedies have been discarded should not lull the present medical generation into a false sense of superiority – on the contrary they should provide us with a corrective to any unbounded confidence in the many theories and pharmaceutical preparations

and in the medical thought and practice of to-day.

Though these authors are now remembered only in the fringes of history, they were nevertheless the enlightened pioneers who endeavoured to keep high the prestige of the Maltese medical profession and to engage the interest of their contemporaries and to stimulate their minds by means of the printed word and thus promote the health of the population of these islands.

Apart from their medical contents, some of these books are of special interest for a study of the printing and publishing of books in Malta in the 18th century because they were printed in the only printing press existing in the Island – that at the Palace of the Grand Master; and because of the censorship by the government, the ecclesiastical authorities and the Inquisitor to which the manuscript had to be submitted before publication. These censors certified that the work submitted for their examination contained nothing against the teaching of the Catholic Church or any subversive matter regarding the state and the Statutes of the Order of St. John. For instance Dr. Cren's *Tractatus* (q.v.) bears the permission to be printed and published of the Bishop of Malta, Fra D. Bartholomeus Rull; of the Inquisitor Angelo Durini; and of the Vice Chancellor, Bali of the Eagle, Fra Franciscus Guedes as representative of the Grand Master.

In addition to the *Censurum vota* and the *Imprimatur* of the three authorities concerned, Dr. J. De Marco's *De Lana* (q.v.) is stamped with the imprint of the Holy Office of Malta on the title page.

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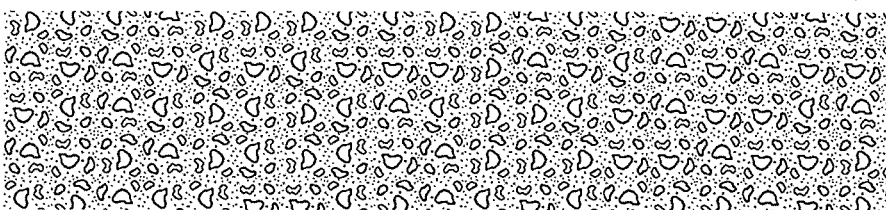
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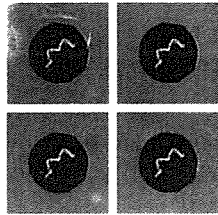
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Cossaesus, J. An fascinatio sit vana superstitio? 1636. An Venus sanitati necessaria? 1636. An odontalgiae nevrotomia? 1636. An eadem sit vis medicamentis quae antiquitus? 1636. An caeparum usus calculosis conveniat? 1636. An in ebullitione sanguinis rubris maculis per corpus erumpentibus vene sectio? 1636. An ictericis balneum aquae tepentis? 1636. An hemicrania pillulae ex aloe? 1636. An molae conceptus requirat utrumque semen? 1637.

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The British Council International Seminars In Britain



Primary care: the best of British practice

The emphasis for health care in Britain has increasingly been shifted into the community.

However, in the last two decades, the triple challenges of rising expectations, rapidly changing clinical practice, and diminishing financial support, have put severe pressures on general practitioners, traditionally seen to be the leaders of primary health care teams.

This seminar will draw together the various ways general practitioners have developed their professional and newly-developed managerial skills into a primary care system, which is broadly based on multidisciplinary primary health care teams.

The objectives of the seminar are fourfold:

Firstly, to show how the delivery of health care has been developed by general practitioners to meet the increasing demands and pressures of the 1990s

Secondly, to illustrate the close integration of general practitioners and other health professionals into the modern primary health care team

Thirdly, to draw upon the model of the NHS purchaser/provider role as an example of how doctors can work with managers to provide good quality, but cost-effective health care

Finally, using national leaders and experts to demonstrate the increasingly important integration of:

- audit and quality care
- research and development
- undergraduate and postgraduate education and teaching
- a sophisticated information system into modern British primary care

There will be opportunities to visit practices and health centres in Wessex in southern England, where a network of primary health care teams provides a high quality of care for a population of three million, as close as possible to patients in their homes.

Great importance will be placed on the interests and special needs of the participants.

The seminar will be directed by:

Anne-Louise Kinmonth

Professor of Primary Medical Care, University of Southampton

Dr David Percy

Associate Postgraduate Dean and Regional adviser in General Practice, South & West Regional Health Authority

Roger Edmonds

General Practitioner, Andover, Hampshire; Chairman, Wessex General Practice Education Committee

Speakers and workshop leaders will be acknowledged experts, to be drawn from a wide range of national and regional sources, and will also include local general practitioners and other members of primary health care teams.

Amongst the speakers to be invited will be:

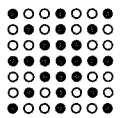
Colin Coles

Lecturer, Department of Medical Education, University of Southampton

Dr Jenny Field

Senior Lecturer and Teaching Co-ordinator, Department of Primary

Primary Care: The Best of British Practice 9-15 November 1995 Southampton Prospectus 9547



Medical Care, University of Southampton – **Dr Robert Gann**
Director of Health for Health, South & West Health Authority –
Professor Chris Ham

Professor of Health Policy and Management, Health Services Management Centre, University of Birmingham – **Dr John Hasler**
Regional Adviser in General Practice, Oxford – **Dr Stephen Henry**
General Practitioner, Trowbridge, Wiltshire; past Chairman, National Association of GP Fundholders – **Dr June Huntingdon**

Consultant in Primary Care Management and Part-time Fellow, King's Fund – **Ken Jarrold**

Director, Human Resources, NHS – **Professor Roger Jones**
Department of General Practice, United Medical & Dental Schools, University of London – **Professor David Mant**

Department of Primary Care Epidemiology, University of Southampton – **Professor Ray Robinson**

Director, Institute of Health Policy Studies, Faculty of Social Science, University of Southampton – **Fran Ross**

Training and Development Manager, Hampshire Family Health Services Authority

It is hoped that the keynote address will be given by **Dr Kenneth Calman**, Chief Medical Officer, United Kingdom

Participants

This seminar is designed for doctors and allied professionals interested in the development of primary health care and also government leaders, officials and managers responsible for developing and influencing health care systems.

Numbers

There are places for 30 participants.

Fee: £1,390

The fee includes:

- the cost of accommodation at Chilworth Manor, the residential conference centre of the University of Southampton; all rooms have private bathroom with shower and wc
- all meals
- full academic programme at Chilworth Manor
- full social programme (including opening dinner)
- welcome and farewell packs (programme, speakers' notes, local information, etc.)
- experienced seminar manager in daily attendance
- emergency medical insurance

This is a residential seminar. We are unable to accept non-resident participants and regret that requests for reductions or refunds cannot be accepted.

Seminar dates

The seminar will commence with an opening dinner on Thursday, 9 November and will finish after lunch on Wednesday, 15 November 1995.

Applications

As the number of places is limited, early application is advised. Expressions of interest may be notified by telephone or fax to International Seminars Department in London, but must be followed up with a completed application form to be assured of consideration.

Applications

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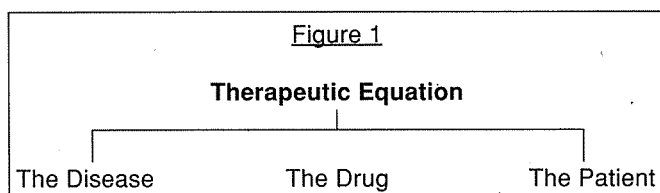
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The purpose of this paper is to provide simple and clear guidelines towards the knowledge that is necessary to allow the sensible use of essential drugs in the management of common conditions. It is important to remember that prescribing drugs is not the only important factor in the management of disease. Indeed it is important to identify and deal with such factors. Such intervention might require the cessation of administration of a specific drug. Moreover non-pharmacological measures are important in the management of such conditions, as hypertension, asthma, diabetes mellitus, hyperlipidaemia, etc.

The aim of all therapy is to administer the appropriate drug in the correct dose to produce the desired therapeutic effect with the minimum of adverse side-effects. Whenever a drug is due to be prescribed, one has to take into consideration the three factors which form the therapeutic equation (Figure 1). One has to take into consideration the disease to be treated, the drug which is most appropriate, and the patient to be treated. I will be reviewing these three aspects by giving examples of diseases which are commonly met in general practice.



The first factor relates to the disease itself. I will discuss two common infections which are seen in general practice – community acquired pneumonias and urinary tract infections. In choosing an anti-infective agent, certain general principles have to be considered (Figure 2). In infections, one has to

Figure 2

Prescribing Anti-Infective Agents

Consider:

1. the known or predicted sensitivity of the likely causative organism(s);
2. in severe infections, a broad spectrum agent or combination of agents;
3. always enquire about previous drug reactions and allergies;
4. all things being equal, always choose the cheaper drugs.

identify the likely aetiological agent and consider the known or predicted sensitivities. In community acquired pneumonia, the likely aetiological agents are those patients where the pneumonia occurs in somebody who previously had a healthy lung and in those who had previously unhealthy lungs are likely to be different (Figure 3 and Figure 4). The antibiotic management in these two clinical settings are different, with erythromycin being the drug of choice in the former and augmentin in the latter.

Figure 3

Antibiotic Regime for Community Acquired Pneumonia in a Healthy Host

- Pneumococcus
- Legionella
- Mycoplasma
- Chlamidia

All Sensitive to
Erythromicin

- Other suggested antibiotics if micro-organisms is resistant
- Tetracycline
- Amoxicillin

Figure 4

Antibiotic Regime for Community Acquired Pneumonia in Patients with Previously Unhealthy Lungs

- Amoxicillin
- Clavulanate – Potentiated Amoxicillin
- Ciprofloxacin
- Cephalosporine + Aminoglycoside in the Hospital Environment

In urinary tract infections, the most common infective agent is Esch. Coli. The most effective treatment for acute cystitis is trimethoprim 200 mgm b.d. or amoxycillin 500 mgm q.d.s. (Figure 5) for 5 days. Acute pyelonephritis, on the other hand, is more serious with augmentin 375 mgm/8 hourly for

Figure 5

Management of UTI

Acute cystitis arising outside hospital	Trimethropin 200mg bd	for 5 days
	OR amoxycillin 500mg x 4	
Acute Pyelonephritis	Augmentin 375mg/8 hourly	for 10 days
	OR Gentamycin + Cefuroxime	
	if severe and patient vomiting requires hospitalisation	

Figure 6

Indications for Further Investigation After Urinary Tract Infection

- Relapsing infection
- Onset of first infection in childhood
- Male sex
- Urological symptoms
- Persistent haematuria
- Unusual organisms (e.g. Pseudomonas spp., Proteus spp.)
- Frequent recurrence (6-week intervals or less)

15 days being the drug of choice. In more severe infections, hospitalisation and parenteral administration of gentamycin and cefuroxime may be necessary. Urinary tract infection, in the clinical settings as listed in Figure 6, are an indication for further investigation. In the primary care setting, non-subsidence of the symptoms within 48 hours of starting the anti-infective agent would suggest resistance to the agent used and a change to another drug is indicated.

In considering the drugs to be used, one has to understand how the drug is handled in the body (Figure 7). They are either metabolised in the liver and/or excreted by the kidney. A drug, on reaching the liver, may undergo extensive inactivation during the first passage in the liver. They may also undergo oxidation or conjugation. Figure 8 lists the various factors involved in the choice of drugs. Any drug that is therapeutically effective is potentially dangerous. Toxic side effects, following drug use, are preventable if one understands the pharmacology of the drug used and the clinical setting in which it is prescribed. On the other hand, though hypersensitivity reactions

Figure 7

Pharmacological Properties of Drugs

Mode in which drug is handled in the body:

- a. metabolised in liver
- b. excreted by kidney:
 1. tubular secretion
 2. glomerular filtration

Figure 8

Practical Problems Related to Drugs

Any drug that is therapeutically effective is potentially dangerous.

1. Choice of drugs
2. Hypersensitivity Reactions
3. Drug Toxicity
4. Drug Interactions

are prevented by a good history, one cannot prevent them altogether. An important area of drug therapy is drug interactions (Figure 9). There are drugs which induce hepatic enzymes and which therefore result in reduced activity of target drugs (Figure 10). On the other hand, the concurrent use of drugs which are hepatic enzyme inhibitors cause an increased activity of the target drugs (Figure 10).

Figure 9

Drug Interactions

1. Drugs which induce hepatic enzymes
2. Drugs which inhibit hepatic enzymes
3. Drug synergism
4. Drug antagonism

Figure 10

Drug Interactions

Enzyme Inhibitors		Target Drugs
Erythromycin Metronidazole co-Trimaxazole Amiodarone Cimetidine	} increase activity of	{ Warfarin Verapamil Carbamazepine Chlorpromazine

Drug synergism (Figure 11) is the most common form of drug interaction. All drugs that have a depressant effect in the central nervous system such as ethanol and benzodiazepenes are synergistic when used concurrently. The use of NSAIDs in somebody who is also taking warfarin might result in accentuation of the anticoagulant effect with potential bleeding. On the other hand, when NSAIDs and hypotensive drugs are used at the same time, they have an

Figure 11

Drug Synergism

This is the most common type of drug interaction

1. All drugs that have an antidepressant function on CNS – ethanol, benzodiazepines, tricyclics, antihistamines, methyl dopa
2. NSAIDs – potentiate warfarin
3. Calcium Channel blockers and B.blockers – heart failure
4. K and Ace inhibitors

antagonistic action with loss of hypertensive effect with the hypertension becoming refractory to adequate control.

The third factor, in the therapeutic equation, is the patient himself. Before one prescribes any drug, one has to evaluate the patient irrespective of the disease to be treated. Figure 13 lists some of the factors involved. In pregnancy, one should question the need for any prescription especially in the first trimester. One should only use agents which have been widely employed in pregnancy for many years rather than new drugs.

Figure 12

Drugs Antagonism

1. B-agonists and B.blockers
2. Vitamin K and warfarin
3. Thiazide diuretics and oral hypoglycaemic agents
4. Penicillin and tetracycline
5. NSAIDS and hypotensive drugs

Figure 13

Evaluation of the Patient Irrespective of the Disease to be Treated

- Age
- Genetic factors
- Pregnancy – mother and foetus
- Renal and hepatic dysfunction
- Diabetes mellitus

Elderly people are frequent users of prescribed medications. The increased prescribing for older people arises in part because they have often multiple diseases that need treatment and in part because doctors tend to respond to every symptom by prescribing a medication. It is definite that drugs tend to be prescribed more often the older people get. Figure 14 lists the commonly used drugs in old age. I doubt whether many elderly patients require so much treatment with diuretics, benzodiazapenes, and NSAIDs.

To conclude I would like to make some observations on the commonly used drugs in old age. Insomnia in the elderly may be a consequence of an underlying disorder such as heart failure, musculo-

Figure 14

Commonly Used Drugs in the Elderly

1. hypnotics and sedatives
2. antidepressants
3. cardiac glycosides
4. NSAIDs
5. Diuretics
6. antihypertensive drugs

skeletal pain, cramps etc. If they have to be used, one should use a short acting agent such as temazepam 5-15 mgm (Figure 15). If the patient is also agitated, chlormethiazole – 250-400 mgm may be the drug of choice.

Depression is common, however as trycyclics undergo oxidative metabolism in the liver, one should start with half the usual dose and increase the dose very slowly. One should consider using the newer drugs such as doxepin which have fewer side effects.

Figure 15

Hypnotics

Use short acting agents – Temazepam 5-15 mgm
 Indications – insomnia with anxiety neurosis; insomnia causing distress to others – carers

Chlormethiazole (Heminevrin) 1-2 capsules (200-400 mgm) especially when associated with agitation

There are also some mis-conceptions about cardiac glycosides. Though a number of people have questioned the need for the digoxin in elderly patients in sinus rhythm, recent evidence suggests that digoxin has a positive inotropic action even in such patients. The dose of digoxin is related to renal clearance, which has been reduced by 50% by the time one has reached the age of 70 years. The geriatric 62.5 µg digoxin tablet seldom gives the right therapeutic concentration unless renal function is markedly compromised (Figure 16). The usual therapeutic dose is 125-250 µg daily.

Figure 16

Cardiac glycosides

Digoxin – dose related to renal clearance.
 – The geriatric tablet 62.5 µg seldom gives therapeutic concentration unless renal function is markedly compromised.
 Often dose is around 125-250 µg.

Digitoxin – Metabolised by liver – no change in dose 100 µg.
 It has a long duration of action.

Diuretics are drugs which are very commonly used in the elderly. I contend that are grossly over prescribed for mild hypostatic ankle oedema. It is worth noting that the combination drugs of diuretics and potassium do not contain enough potassium. This is very important when diuretics are used in conjunction with cardiac glycosides. Confusion and falls in the elderly may be secondary to the hyponatraemia as well as hypotension induced by the diuretics. The combination of a diuretic with a potassium sparing agent is more logical.

NSAIDs often cause adverse reactions in the elderly (Figure 17). They are potentially dangerous in patients with impaired renal function for renal perfusion in the elderly is dependent on prostaglandin mediated blood flow; the NSAIDs being prostaglandin synthetase inhibitors. One should be careful when prescribing such drugs in patients with heart failure, hypertension and renal disease. Ibuprofen has fewer side effects but its anti-inflammatory properties are weaker.

Figure 17

NSAID

Often cause adverse reactions in elderly.
Renal perfusion in elderly is dependent on prostaglandin mediated blood flow.

NSAID → heart failure and loss of control of hypertension
Propionic acid derivatives – ibuprofen – fewer side effects but anti-inflammatory properties weaker.
Feldene should not be used because of its long 1/2 life.

Figure 18 lists the various hypotensive agents which are available and their effect on glucose and lipids. This is important as both hypertension and

diabetes mellitus are very common at this age group. The ACE inhibitors, α-blockers and calcium channel blockers are the drugs least likely to influence adversely the diabetic state.

The basic principles underlying safe prescribing in the elderly is shown in Figure 19; indeed this applies also to younger individuals. The importance of careful clinical assessment, using slow starting doses and a simplified dose and drug regime is rightfully stressed. It is important when in doubt, not to prescribe. It is also vital to check on various drug interactions and adverse side-effects, when one is not certain, by consulting a recent edition of the British National Formulary which one should keep close at hand.

Figure 19

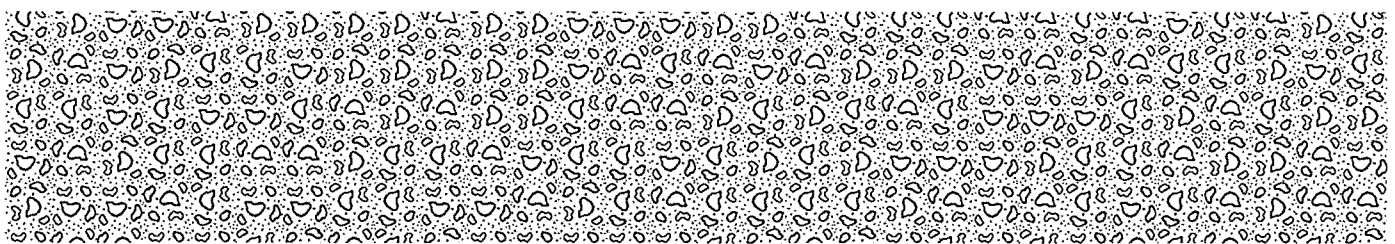
Safe Prescribing for the Elderly

1. Make a careful clinical assessment
2. Know your drugs: side effects, doses
3. Use low starting doses
4. Simplify dose and drug regime
5. Review the medication regularly
6. Maintain good compliance: check for problems
7. Remember about adverse drug reactions
8. When in doubt, don't prescribe

Figure 18

Antihypertensive Agents

Thiazides	Glycaemic Control in NIDDM ↓ Plasma Lipids ↑
β-Blockers	Hyperglycaemia in NIDDM Hypoglycaemia in NIDDM and Insulin Treated NIDDM Triglycerides ↑ HDL ↓
Calcium Antagonists	No Known Effects
α-Adrenergic Blockers	Glycaemic Control not Affected Orthostatic Hypotension
Ace Inhibitors	Improve Glomerular Filtration and Decrease Albuminuria in Patients with Nephropathy. May Improve Renal Function Even in Normotensive Patients with Nephropathy.



Day 1: Wednesday 18th January 1995

**Sensible Prescribing in Family Practice:
– Profs. F.F. Fenech**

A Lesson I've Learnt – Dr J. Portelli Demajo

Doctors present: 50
Forms returned: 23

*Today's seminar was relevant to
family medicine/general practice:*

Disagree: 0
Undecided: 0
Agree: 23

*Today's seminar increased my knowledge
and/or awareness of issues:*

Disagree: 0
Undecided: 1
Agree: 22

*My patient care will be modified
as a result of this seminar:*

Disagree: 0
Undecided: 9
Agree: 22

The best feature of today's seminar was:

Sensible Prescribing (x14)
Both (x1)

Today's seminar would have been better if:

If Lecture was shorter
Better Overheads (Dr. Portelli Demajo)

*Please suggest your name to speak on a specified
topic in future CPD meetings:*

Nil

Day 2: Thursday 19th January 1995

**More Pitfalls of The Chest X-Ray
– Dr M.P. Crockford**

How I Manage – Dr M. Schembri

Doctors attending: 41
Forms returned: 26

*Today's seminar was relevant to
family medicine/general practice:*

Agree: 23
Undecided: 3
Disagree: 0

*Today's seminar increased my knowledge
and/or awareness of issues:*

Agree: 25
Undecided: 1
Disagree: 0

*My patient care will be modified
as a result of this seminar:*

Agree: 16
Undecided: 8
Disagree: 2

The best feature of today's seminar was:

Pitfalls of the C.X.R. (x8)
How I Manage short and sweet (x1)

Today's seminar would have been better if:

Better audio visual aids Dr M.
Schembri (x3)
Dr Schembri talked slower
No mobile phones

*Please volunteer your name to speak on a specified
topic in future CPD meetings:*

Dr C. Zarb
Aputs Syndrome

Day 3: Friday 20th October 1995

**The Role of The Community Nurse in Family
Practice – a Video Forum presented by the:
Malta Memorial District Nursing Association**

Mr L.E. Galea – Chairman

Major M.G. Agius – General Director

Mrs R. Farrugia – District P.N.O.

Doctors attending: 42
Forms returned: 26

*Today's seminar was relevant to
family medicine/general practice:*

Disagree: 2
Agree: 23
Undecided: 1

Today's seminar increased my knowledge and/or awareness of issues:

Disagree: 3
Agree: 23
Undecided: 0

My patient care will be modified as a result of this seminar:

Disagree: 5
Agree: 19
Undecided: 2

The best feature of today's seminar was:

Video (x2)
Mrs Farrugia explanation

Today's seminar would have been better if:

No comments

Please suggest your name to speak on a specified topic in future CPD meetings:

Nil

(Compiles by Dr. Anthony Mifsud M.D.,
Secretary for Research)



EVALUATION OF THE SPRING CPD MEETING

26-28 APRIL 1995

Day 1: Wednesday 26th April 1995

Immunization – Latest Development

– Dr. R. Busuttill M.B., Ch.B., D.C.H., F.R.C.G.P.

A Lesson I've Learnt

– Dr Peter A. Fenech, M.D. D.P.H.

Doctors present: 48
Forms returned: 25

Today's seminar was relevant to family medicine/general practice:

Disagree: 0
Undecided: 0
Agree: 25

Today's seminar increased my knowledge and/or awareness of issues:

Disagree: 0
Undecided: 1
Agree: 24

My patient care will be modified as a result of this seminar:

Disagree: 0
Undecided: 2
Agree: 23

The best feature of today's seminar was:

Immunization (x12)

Today's seminar would have been better if:

Shorter
Better Overheads of 2nd talk
Shorter presentation of 2nd talk with less rambling
Issue of lecture notes
Meeting started on time

Please suggest your name to speak on a specified topic in future CPD meetings:

Nil

Day 2: Thursday 27th April 1995

Epidemiology in Family Practice

– Dr Julian Mamo, M.D., M.Sc.

How I Manage –

Dr George Grech, M.R.C.S., L.R.C.P.

Doctors attending: 36
Forms returned: 19

Today's seminar was relevant to family medicine/general practice:

Agree: 19
Undecided: 0
Disagree: 0

Today's seminar increased my knowledge and/or awareness of issues:

Agree: 17
Undecided: 2
Disagree: 0

My patient care will be modified as a result of this seminar:

Agree: 18
Undecided: 1
Disagree: 0

The best feature of today's seminar was:

Epidemiology (x1)
Drug Abuse (x4)
Both (x4)

Practical and illuminating talks
Good visual aids (x2)

Today's seminar would have been better if:
Started on time
Started Later (especially summer time)

Please volunteer your name to speak on a specified topic in future CPD meetings:
Nil

Today's seminar increased my knowledge and/or awareness of issues:

Disagree:	12
Agree:	16
Undecided:	0

My patient care will be modified as a result of this seminar:

Disagree:	4
Agree:	24
Undecided:	0

Day 3: Friday 28th April 1995

Psychology and Counselling in Family Practice

Mr Paul Sciberras, M.Sc.

The role of the Psychologist in Family Practice

Mr Paul Sciberras, M.Sc.

The use of Counselling by the Family Doctor

Dr Graham Curtis Jenkins, M.A., F.R.C.G.P.

Doctors attending: 45
Forms returned: 28

Today's seminar was relevant to family medicine/general practice:

Disagree:	4
Agree:	24
Undecided:	0

The best feature of today's seminar was:

Dr Jenkin's presentation (x12)
Mr Paul Sciberras's presentation (x2)
Both (x2)

Today's seminar would have been better if:

Transperancies of 1st talk more clearly done
1st talk was more like a lecture rather too trivial for C.P.D.
Less reading during 1st talk

Please suggest your name to speak on a specified topic in future CPD meetings:

Computers in General Practice
- Dr J.K. Soler

(Compiles by Dr. Anthony Mifsud M.D.,
Secretary for Research)



ROYAL COLLEGE OF
GENERAL PRACTITIONERS

**THE MANAGEMENT OF BACK
PAIN IN GENERAL PRACTICE**
MARTIN BARKER FRCGP

General practitioners might be forgiven for thinking that all their patients have a bad back. However, 'good' backs do exist - in fact, they are three times more common than bad backs in the patients seen in general practice. Yet the complaint of backache seems to be one area of clinical practice where no clear diagnosis can be made. Only one-third of people with an episode of low back pain consult their doctors, and a general practitioner with a list size of 2000 patients can expect to see between 60 and 100 new episodes of back and leg pain each year.

In this monograph, Martin Barker comprehensively reviews the literature and offers very practical advice on the management of back pain in general practice. He writes clearly from the perspective of a family

doctor with a deep interest in the subject and many years of experience of dealing with the problems of back pain.

While primarily targeted at general practitioners, this publication could also be read with benefit by orthopaedic surgeons and physical therapists.

For enquiries about the content of the book please contact: Dr Martin Barker, The Surgery, The Sheepmarket, Stamford, Lincolnshire PE9 2SL; Tel: 01780 53151.

Copies are available from:
RCGP Sales
14 Princes Gate
Hyde Park
London
SW7 1PU
Tel: 0171 823 9698

Price £9.00 (£9.90 non-members) including postage. Access and Visa are welcome, 24 hour answerphone. Tel: 0171 225 3048.

I thank the college for inviting me to make this presentation on how I manage alcohol related problems in my practice. The hypothetical case is one of a middle-aged businessman who, during one of his rare visits, complains of symptoms of anxiety and difficulty in sleeping, attributed to pressures at work. During questioning he avoids my probing into his alcohol intake, but does reveal that his wife is being treated by another doctor for depression.

Notwithstanding the patient's reluctance, it is essential that one should investigate the quantity and quality of alcohol intake and the relationship of the suspected abuse of alcohol to the patient's social, family and personal problems.

It is important to assess whether alcohol intake is in fact excessive, and thus the daily quantity drunk should be determined. A critical level which may trigger dependence is approximately 150 ml per 24 hours, or approximately $\frac{1}{2}$ a bottle of spirits, $1\frac{1}{2}$ bottles of wine, or 4 to 7 pints of beer. Pointed questions should be asked to look for specific features which, if present, indicate a tendency to alcohol dependence. It may be very difficult to differentiate heavy social drinking from alcoholism, but the presence of these features is indicative.

Features of Alcoholism

1. Inability to abstain
2. Alcoholic "blackouts" – pt. forgets what happened during last night's binge
3. Decreased memory capability, concentration and ability to work profitably e.g. frequently late to work on Monday, following weekend
4. Accident prone – especially car accidents
5. Emotional lability with outbursts of rage followed by remorse
6. Bonhomie with drinking companions but inconsiderate and self-centred with family
7. Deteriorating sex life due to inconsiderateness
8. Thinking about drink – about getting a drink – about stopping
9. Early drinking to combat early morning "shakes" due to night-time abstinence

Next, one would investigate the relationship between alcohol abuse and the patient's problems. Alcoholism may be symptomatic of underlying mental illness, and the psychotic patient may drink to dull

feelings of depression, delusions or hallucinations; therefore one must keep in mind that the patient's anxiety and sleep disorder may be due to causes other than pure alcoholism. In the majority of cases the symptoms are mainly alcohol related and should improve with improved control of drinking.

The patient should be asked about his home situation and whether his drinking has brought on domestic conflict and contributed to his wife's depression, or whether he is drinking because of his anxieties about his spouse's health problems. The patient's marital relationship is very relevant in that family support plays a crucial role in helping the patient to stop.

One would enquire about smoking, heavy smoking being prevalent in individuals prone to use alcohol as an escape mechanism. Poor eating habits, with little regard to eating a balanced diet is also common. In extreme cases diet may be very poor, predisposing to vitamin deficiencies and complex health problems.

A detailed social history is taken, with reference to the patient's work environment and work relationships. A drug history is also taken with details of use or abuse of tranquillisers and sleeping tablets, compliance with other medication, such as anti-hypertensive treatment, and, if appropriate, use of illicit drugs. One would also ask about other symptomatology, such as heartburn, shortness of breath, chest pain, haematemesis and melaena, etc.

During the physical examination, one would pay attention to general physical health and body habitus. One looks for the stigmata of liver disease, such as jaundice, palmar erythema, gynaecomastia, finger clubbing, spider naevi, etc. Chest and cardiovascular assessment is carried out, and abdominal examination should include palpation of the liver and spleen to assess size and texture, and digital rectal examination to detect haemorrhoids. Haematological investigations should include parameters which may indicate abuse and may serve to monitor abstinence, such as MCV and Gamma-GT which are elevated in alcohol abusers.

Complications of Alcohol Abuse

1. Psychosocial domestic conflict, assault, wife and baby battering, road accidents, loss of work, homicide, suicide,

2. Physical obesity, early morning nausea & vomiting, tremors, suffused facies heavy smoking, laryngitis, tracheitis, bronchitis, gastritis, peptic ulcer pancreatitis, acute and chronic liver disease: fatty liver, hepatitis, cirrhosis, liver failure bleeding oesophageal varices dysrhythmias, cardiomyopathy polyneuritis, cerebellar degeneration, retrobulbar neuropathy falls and subdural haematoma epileptic fits anaemia, haemolysis alcoholic hallucinations, delirium tremens Korsakow's psychosis, Wernicke's encephalopathy dementia

Alcoholism

Alcohol induces a feeling of warmth, wellbeing and exhilaration, but is a cerebral depressant and thus keeps anxiety, conscience and self-criticism at bay. Teetotallers can metabolise 7 to 20 ml of alcohol per hour, but chronic drinkers can metabolise much more and also develop central nervous system tolerance. Thus tolerance may be considerable, but although appearing sober their reflexes may be dulled and their capability to perform complex tasks such as driving may be severely impaired.

Prevalence is on the increase in both sexes, but it is difficult to quantify because of reluctance to see a doctor due to lack of insight, fear of ridicule or of a hostile reaction, and socio-economic repercussions. Many cases present due to domestic conflict or car accidents. It may also be difficult to distinguish from heavy social drinking, which may however develop into more obvious dependence.

Primary alcoholism is due to a conditioned reflex such as demonstrated by Pavlov, where drinking brings on relief from anxieties, conscience or internal conflict. Alcoholism may also be secondary to mental illness, bringing relief from delusions of persecution, nagging hallucinations or depression. Susceptibility may be hereditary, but a positive family history is not found in all cases. Occupational exposure play a part and prevalence is higher in bartenders, but also actors and other entertainers, armed forces personnel, medical practitioners and insurance brokers. Age is usually over thirty but prevalence in teenagers is on the increase. In females a different picture prevails with home or "wardrobe" drinking.

Management

Motivation and co-operation essential
Examine patient's life situation and determine difficulties to be solved
Enlist help of spouse and family – make drink and money less available
Refer to self-help group, e.g. A.A.
? antabuse
? behavioural therapy – reverse conditioning
– mix drink with foul tasting substance
– electric shocks

Goals

To stop all drink at once may be counterproductive – pt. drinks in defiance "I AM NOT SICK!"
Teach patient to estimate intake and keep an "alcoholic diary", listing successes and failures
Feedback with improvements – weight, MCV, gamma-GT

Tricks

Limit to social occasions – sip not gulp
Decrease frequency of sips – shadow a slow drinker and put down your glass with him to avoid subconscious sipping
Drink more non-alcoholic drinks
Don't buy yourself a drink when buying a round
Decrease the period of drinking – go out to the bar later
Rest days with no drinking
Catch phrases to refuse a drink – "no thanks, I have to drive home"

Conclusion

In conclusion, alcoholism is a commonly encountered problem in family practice, and the family doctor is in a unique position to treat it in the family setting, addressing more aspects of the problem and recruiting the help of the family as a whole. Successful treatment, although difficult to achieve, will improve the patient's physical and mental health, allow him to improve his home and work situation and avoid debilitating and potentially life-threatening complications, and this makes for a very satisfying challenge for the family doctor to meet.

Thank you for your attention.

On Saturday 29th April 1995, a one-day Workshop on Counselling in Family Practice was held by the Malta College of Family Doctors for 26 of its members at the Federation of Professional Bodies, Medisle Village, St Andrew's generously sponsored by Interpharma Co. Ltd., local representatives of Mepha Swiss pharmaceuticals.

The workshop was led by Dr Graham Curtis Jenkins MA FRCGP, Director of the Counselling in Primary Care Trust, Staines, UK, a national expert on the subject, who was kindly nominated by Dr Philip R. Evans FRCGP, Chairman of the International Committee of the Royal College of General Practitioners. His co-leader was Ms Jennifer Pace B.Ed. (Hons) BA MA, a local counselling psychologist.

Counselling forms an integral part of a family doctor's practice, although doctors do not receive any formal training in this skill. Mindful of its responsibility to undertake educational activities designed to enhance the knowledge and skills of family doctors, the Malta College of Family Doctors decided to hold this workshop on counselling.

The workshop was preceded by an introductory evening forum on 'Psychology and Counselling in Family Practice' on Friday 28th April at the University of Malta Medical School. Mr Paul Sciberras MSc, a local clinical psychologist nominated by the Malta Union of Professional Psychologists, opened the evening with a presentation on 'The Role of the Psychologist in Family Practice', followed by Dr Graham Curtis Jenkins who kindly spoke on 'The Use of

Counselling by the Family Doctor'. The discussion was then opened to the audience of family doctors, and concerned mainly the training and registration of local psychologists and counsellors.

The Workshop on Counselling in Family Practice the day after consisted not only of presentations by Dr Curtis Jenkins and Ms Pace, but also involved role play undertaken by the participants themselves. The latter thus had the chance of trying out a simple but effective five-step set of questions designed to help the doctor to guide the patient in expressing his feelings, while listening and providing an emphatic response.

Taken from the book "*The fifteen minute hour: applied psychotherapy for the primary care physician*" by Marian R. Stuart and Joseph A. Liebermann III, these questions can be recalled through the mnemonic B-A-T-H-E, where B stands for Background, A for Affect, T for Trouble, H for Handling and E for Empathy.

At the end of a hard-working but fruitful day, Dr Mario R. Sammut, College Secretary and organiser of the workshop, thanked one and all for their active participation, and invited Dr Curtis Jenkins to present certificates of attendance to the following: Dr Anthony P. Azzopardi, Dr Louis Bonello, Dr Michael A. Borg, Dr Alexandra C. Buttigieg, Dr Timothy Camilleri, Dr Alessandra Falzon Camilleri, Dr Frank Fenech, Dr Tanya Fenech Melilo, Dr Patrick Frendo, Dr Wilfred Galea, Dr George Grech, Dr Anthony Livori, Dr Anthony Mifsud, Dr Tania Mizzi, Dr Joseph G. Pace, Dr Jacqueline Padovani, Dr Lucienne Portelli, Dr Mark Rosso, Dr Mario Saliba, Dr Carmen Sammut, Dr Mario R. Sammut, Dr Anthony M. Schembri, Dr Philip Sciortino, Dr Denis Soler, Dr Jean Karl Soler and Dr Valerio Vella Catalano.

The same evening Dr Curtis Jenkins and Ms Pace were the guests of honour of the College Council at a delicious dinner at '*La Dolce Vita*', a popular restaurant overlooking the picturesque bay of St Julian's. Dr



The accompanying group photograph shows most of the participants, including (third from left, seated) Dr Denis Soler (College President), Dr Graham Curtis Jenkins (leader), Ms Jennifer Pace (co-leader), and Dr Mario R. Sammut (College Secretary and organiser of the workshop).

Denis Soler, the College President, brought the enjoyable occasion to a close by auguring many more future collaborations with the Royal College of General Practitioners and with both leaders, presenting the latter with small tokens of gratitude for their help.



This photograph shows Dr Graham Curtis Jenkins (left) being presented with his memento by Dr Denis Soler.



**ROYAL COLLEGE OF
GENERAL PRACTITIONERS**

**DRUG EDUCATION
IN GENERAL PRACTICE
OCCASIONAL PAPER 69**

William Osler is said to have remarked that the desire to take drugs was one of the main distinguishing features between humans and animals. In most societies the prime responsibility for prescribing drugs lies with doctors; it is part of the medical process and reflects directly the diagnosis made. Education in prescribing is therefore of paramount importance.

In 1992 the European Academy of Teachers in General Practice (EURACT) was established at Gleneagles with the aim of fostering and maintaining high standards of care in European general practice. It chose as its theme for its first major conference the place of drug education in general practice and it brought together a number of leading European thinkers in the field.

A selection of papers from the conference is now published as *Occasional Paper 69* under the Editorship of Professor Michael Kochen, Head of the Department of General Practice, University of Goettingen. The main themes concern the increasing role of the patient as consumer, the increasing availability of data about prescriptions issued by general practitioners, and the continuing conviction that the use of drugs is likely to remain a vital component of quality of care in general practice.

Drug Education in General Practice, Occasional Paper 69 is available from RCGP Sales, price £12.00 (£13.20 non-members) including postage. Access and Visa are welcome, 24 hours. Tel: 0171 225 3048.

Enquiries should be made as follows:

Content	Sales
Professor M Kochen	RCGP Sales
Leiter der Abteilung Allgemeinmedizin	14 Princes Gate
Georg-August-Universität-Goettingen	Hyde Park
Robert-Koch Strasse 42	London
D-37075	SW7 1PU
Goettingen - Germany	
Tel: 010 49 551 392 638	Tel: 0171 823 9698



**ROYAL COLLEGE OF
GENERAL PRACTITIONERS**

**SIGNIFICANT EVENT AUDITING
A STUDY OF THE FEASIBILITY AND POTENTIAL OF
CASE-BASED AUDITING IN PRIMARY MEDICAL CARE
OCCASIONAL PAPER 70**

Significant Event Auditing reports a new educational method of conducting audit, which, while building on the concept of 'critical incident analysis', does not necessarily imply fault or criticism.

Professor Michael Pringle and colleagues conducted a study involving 20 practices, 10 rural and 10 urban, half of which carried out significant event auditing over a period of a year, and half of which carried out conventional audits. The results of audits on a wide range of topics are given and the two methods compared and contrasted.

This research is important for the new emphasis it places on qualitative review; for the emphasis it places on the whole person; and for the emphasis it places on people working together in the practice setting rather than elsewhere.

Significant Event Auditing, A Study of the Feasibility and Potential of Case-based Auditing in Primary Medical Care, Occasional Paper 70 is available from RCGP Sales, price £15.00 (£16.50 non-members) including postage. Access and Visa are welcome, 24 hours. Tel: 0171 225 3048.

Enquiries should be made as follows:

Content	Sales
Professor M Pringle	RCGP Sales
Department of General Practice	14 Princes Gate
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Nottingham	London
NG7 2UH	SW7 1PU
Tel: 010 49 551 392 638	Tel: 0171 823 9698

CONTINUING PROFESSIONAL DEVELOPMENT 1995 PROGRAMME

Accreditation is to take the form of credit units and the system of credit allocation will take into consideration both active and passive involvement in Continuing Professional Development (CPD) activities, the former attracting more credit units than the latter. Each member of the College must accumulate 27 units annually to retain the right to membership. A CPD logbook has been distributed to all members to allow recording of credit units as they are accumulated.

SOURCES OF CREDIT UNITS

Informal (Active) Learning:

1. Presentation of lecture at College or PGMCC CPD activity **5**
2. Publication of paper in College or other medical journal **5**
3. Active participation in research, such research to be approved by Council for accreditation purposes **max 10**
4. Acceptance of a medical student for a training attachment as organised by the Faculty of Medicine **1 unit per student per week**
5. Any other activity which a member feels may attract credit units after submission to Council for approval for such purpose **Discretion of Council**

Formal (Passive) Learning:

1. Attendance at CPD lectures organised by the College or PGMCC. The units attracted by each lecture will be published by the College beforehand **3, 2, 1**
2. Attendance at any CPD activity other than those specified in 1 above; such activity to be approved by Council for accreditation purposes .. **max 2**
3. Attendance at any local/overseas conference/course after approval by Council for accreditation purposes **Discretion of Council**

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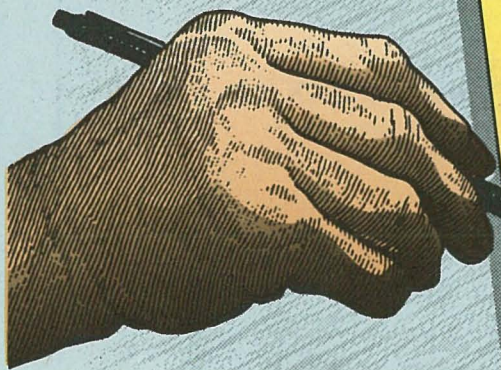
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"It-Tabib tal-Familja", Malta College of Family Doctors, Alamein Road, Medisle Village, St. Andrews STJ 14, Malta.
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PROTECTING YOUR FAMILY'S HEALTH



YES NO Answer the following questions:

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