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Editor's Note

You will have noticed that there are fewer articles in this issue against the last. This is due to my having less material to work with – infact I was promised three more articles which, for one reason or another, were never delivered. To improve the quality of our journal, which I believe is our common aim, a constant supply of articles is essential and I ask you to make a contribution, however small, towards this aim.

May I take this opportunity to join the Council in wishing all our colleagues and their families a Merry Christmas and a Happy New Year.

Jean Karl Soler.

Winter C.P.D. Meeting

Wednesday, 19th January 1994
Gastro-oesophageal Disease - *Dr. E. Pullicino*
How I manage ... - *Dr. J. Padovani*

Thursday, 20th January 1994
A Naval Medicine Chest of the 17th Century from Malta - *Dr. Paul Cassar*
What I've learnt - *Dr Doreen Cassar*

Friday, 21st January 1994
Tha Family Doctor and Abuse in the Family
Panel Discussion

Continuing Professional Development — 1994 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 PGMC 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 PGMC. 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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Forty-a-day smokers between ages 30-35 shorten their life expectancy by 8-9 years

WHAT IS SMOKING?

• PSYCHO SOCIAL HABIT

20 cigarettes a day mean 200 hand-to-mouth movements and puffs a day; 6,000 a month; 72,000 a year; or more than 2,000,000 for a 45-year-old smoker who started at 15.

• PHARMACOLOGICAL DEPENDENCE

Nicotine reaches the brain within 7 seconds of inhaling tobacco smoke, twice as fast as if it were injected intravenously. Due to the short half-life nicotine has in the body, craving occurs within minutes of finishing a cigarette.

Habitual cigarette smoking fits the WHO criteria for addiction:

•The compulsion to take a drug (nicotine)

•on a continuous basis (200 shots a day)

•in order to experience its effects (small doses stimulate, large doses sedate),

•or to avoid the discomfort of its absence (anxiety, irritability, tremor, loss of concentration, memory impairment, insomnia, constipation, weght gain, craving).

(WHO definition of addiction as adapted by Dr Chris Steele)

THE PATHOPHYSIOLOGY OF SMOKING

Smokers smoke for the effects of nicotine, but suffer the morbid and mortal effects of carbon monoxide and smoke condensate (tar), the latter containing 4,000 different chemicals, including 300 known carcinogens.

1. NICOTINE

- Acts on the central and autonomic nervous systems by stimulating the brain's nicotinic receptors, causing changes in mood, learning, concentration, alertness and performance.
- Triggers the release of chemicals that increase heart rate, vasoconstriction (analogy of 'one foot on the accelerator, the other on the brake'), blood pressure, blood clotting, and oxygen consumption.

2. CARBON MONOXIDE.

- Attaches readily to the haemoglobin in the blood, preventing it from carrying the maximum amout of oxygen to the body's tissues, this being especially compromising in cardiac disorders, asthma and pregnancy.
- In the cardiovascular system, may produce intimal hypoxia and increase endothelial permeability, repeated insults encouraging lipid deposition.

3. SMOKE CONDENSATE (TAR)

- Carcinogens contribute to the development of cancer in the lung through inflammation with associated ulceration and squamous metaplasia.
- Other irritants narrow the bronchioles and promote ciliostasis. Increased numbers of macrophages and neutrophils release elastase into the lungs, leading to emphysema.

ATHEROGENESIS is also promoted by smoking which:

- decreases high density lipoprotein cholesterol, and
- increases low density lipoprotein cholesterol, total serum cholesterol and free fatty acids in the plasma.

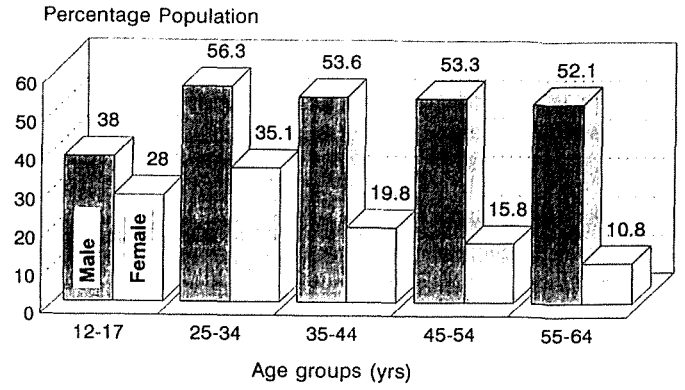
TOBACCO-RELATED DISEASES

(WHO – WORLD NO-TOBACCO DAY 1993)

- **CANCER**
  Lung
  Larynx
  Pharynx
  Oral Cavity
  Oesophagus
  Pancreas
  Kidney
  Bladder
  Cervix
  Leukaemia *(some forms)*
- **CARDIOVASCULAR DISEASE** *(Cumulative effects with oral contraception)*
  Coronary Heart Disease
  Stroke
  Peripheral Vascular Disease
  Aneurysm
- **CHRONIC OBSTRUCTIVE LUNG DISEASE**
  Chronic Bronchitis
  Emphysema
  Asthma
- **COMPLICATIONS OF PREGNANCY**
  Spontaneous Abortion
  Low Birth Weight
  Perinatal Death
  Congenital Malformation
- **OTHERS**
  Peptic Ulcers
  Oral Ulcers
  Gum Disease & Tooth Loss
  Reduced Fertility
  Osteoporosis
  Lower Respiratory Infections

Table 1 - SMOKING

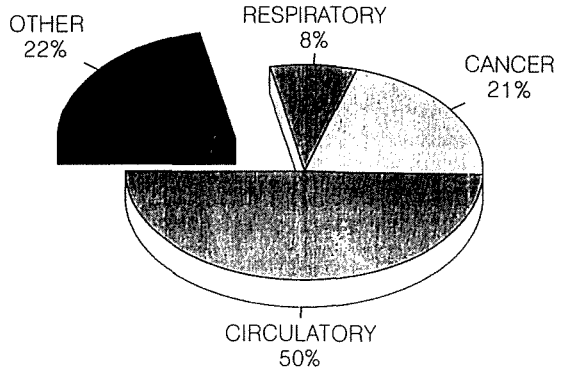
Smoking prevalence in Malta by age and sex



Sources: 1990 MONICA / 1992 PRIDE-CARITAS

Table 2 - MORTALITY

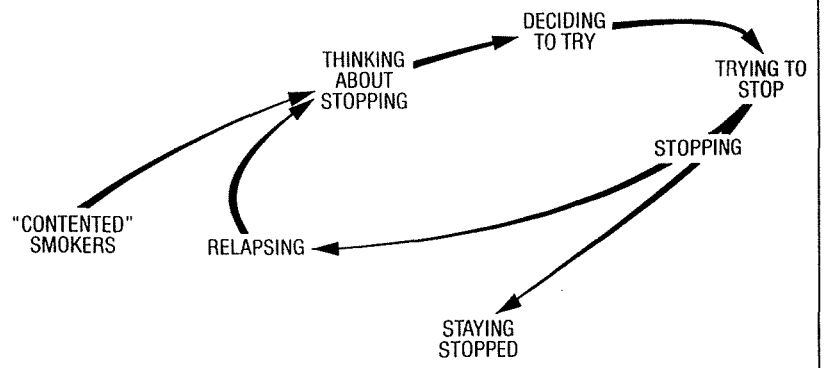
Causes of Death in Malta, 1990



Source: HISU

Table 3 - STOPPING SMOKING IS A PROCESS

Advice can start ot off, or help it along sa little further



HELP YOUR PATIENT STOP

The local situation

In Malta, over half of adult males and about one-third of adolescents smoke *(see Table 1).*

In 1990, 79% of local deaths were caused by cancer and circulatory/respiratory disorders *(see Table 2).*

According to a WHO Fact Sheet published for World No-Tobacco Day 1992, in populations where cigarette smioking has been common for several decades (which is certainly the case with Malta), about:

- 80-90% of lung cancer,
- 80-85% of chronic bronchitis & emphysema, and
- 20% of deaths from heart disease and stroke

are attributable to tobacco!

Therefore tobacco smoking, which is highly prevalent locally, is strongly associated with the three main killer diseases in Malta.

The Charter Against Tobacco

The first European Conference on Tobacco Policy in Madrid in 1988 endorsed a charter recognising people's moral right to be protected not only from the diseases tobacco causes but also from the pollution created by tobacco smoke. The last two points of this charter are very relevant here:

- Each citizen has the right to be informed of the unparalleled health risks of tobacco use.

- Every smoker has the right to receive encouragement and help to overcome the habit.

The effectiveness of advice against smoking

Stopping smoking is a process. Advice can start it off, or help it along a little further *(see Table 3).*

In the UK, Russell et al showed in 1979 that following simple advice to stop, reinforced by a leaflet and warning of follow-up, 5% of GP's patients were not smoking a year later.

Moreover, a study done on the outcome of six smoking cessation clinics held locally by the author for the Health Education Unit between July 1991 and June 1993, showed tht 30% of the smokers were not smoking eight weeks later *(see Table 4)*.

Table 4 - Health Education Unit Smoking Cessation Clinic Programme

Session 1		Introduction
Session 2	*After one week*	Quit Day
Session 3	*After one week*	Follow-Up
Session 4	*After one week*	Follow-Up
Session 5	*After two weeks*	Follow-Up
Session 6	*After two weeks*	Follow-Up
Session 7	*After two weeks*	Final session

Dr Mario R Sammut MD

SMOKING CESSATION CLINICS: *RESULTS*	*ATTENDED QUIT SESSION (2)*	*QUIT SMOKING BY FINAL SESSION (7)*	*SUCCESS RATE (% OF QUIT SESSION)*
Clinic 1 Floriana *Jul-Sep 1991*	12	1	8 %
Clinic 2 Floriana *Feb-Apr 1992*	4	1	25 %
Clinic 3 Qormi *Jun-Aug 1992*	12	3	25 %
Clinic 4 Qormi *Oct-Dec 1992*	8	5	62 %
Clinic 5 Floriana *Jan-Mar 1993*	10	5	50 %
Clinic 6 Qormi *Apr-Jun 1993*	17	4	24 %
TOTALS	**63**	**19**	**30 %**

FOUR A's to
"How to Help Your Patients Stop Smoking"
(US National Cancer Institute, 1990)

1. ASK about smoking at every opportunity
2. ADVISE all smokers to stop
3. ASSIST the patient in stopping
4. ARRANGE follow-up visits

1. Ask about smoking at every opportunity

(A) "Do you smoke?"

- *especially to those with symptoms of:*
- cough, sputum production
- chest pain, shortness of breath

- *and to those at special risk through:*
- coronary / central / peripheral vascular disease
- hypertension
- bronchitis / emphysema / asthma
- recurrent respiratory infections
- diabetes mellitus
- hypercholesterolaemia
- peptic ulcer
- allergy
- before and after surgery
- women on the pill
- pregnancy and post-delivery
- parents of young children

- ***Record smoking status in notes:***
- black sticker for smokers
- yellow sticker for those trying to quit
- blue sticker for non- or ex-smokers (congratulate the latter)

(B) "How much? How early do you smoke your first cigarette?"

- *Typically, the addicted smoker:*
- smokes more than 25 cigarettes a day
- smokes within 30 minutes of waking

(C) "Have you ever tried to stop? If so, what happened?"

- Difficulties experienced then, will help in preparation for quitting now.

(D) "Are you interested in quitting now?"

2. Advise all smokers to stop

(A) Give a firm, simple no-smoking message such as:

- "I am concerned about your smoking. I must strongly recommend that you quit."

(B) Personalise the message to quit

- by linking it as closely as possible to the smoker's physical condition.

(C) Reinforce any interest in stopping

- *by stating the risk in terms which are easy to understand:*

"Smoking IS dangerous"
- "9 in 10 of deaths from lung cancer, chronic bronchitis and emphysema, and 1 in 4 of heart disease deaths, are CAUSED BY SMOKING!"
- From an average 1,000 young men who smoke cigarettes regularly: about 1 will be murdered, about 6 will be killed on the roads, and about 250 WILL BE KILLED BY TOBACCO!"

"It IS worth stopping"

- "Quitting smoking once and for all cuts the added risks of death and disease WITHIN 10 TO 15 YEARS."
- "If you stop smoking today, by tomorrow you will have HALVED YOUR CHANCES of dying of a heart attack!"

(D) Close consultation or continue

- *If not interested*
- offer a booklet (Taf x'jagħmillek it-tipjip ... Aqra ftit)
- advise further consideration
- give an open invitation for further discussion
- ask again at next visit

3. Assist the patient in stopping

- Reassure patient that many smokers find that quitting is much easier than they imagined – if they have the WILLPOWER and the WANT POWER.

(A) "Prepare carefully"

- Write down your own reasons for quitting
- Keep a smoking diary of when, where and with whom you smoke so that coping strategies can be planned beforehand.
- Be aware of nicotine withdrawal symptoms – most will pass within a few weeks
- Set a quit date – within 1 to 4 weeks, avoiding periods of stress
- Enlist the support of family or friends – quit with a friend
- Read self-help literature (Trid tieqaf tpejjep? Ara kif ...)

(B) Wake up as a non-smoker

- Remove any temptation – "just one" cigarette leads to another
- Using the Stop/Think/Act technique, implement coping strategies (hands, mouth, mind) in the leaflet 'X'nistgħu nagħmlu flok li npejpu'
- Change your routine – keep yourself busy
- Avoid worrying about the future – take one day at a time
- Eat healthy food, take more exercise, get plenty of rest
- Be nice to yourself – cash not ash

(C) Consider prescribing nicotine replacement therapy

4. Arrange follow-up visits

- Three visits at weekly intervals, followed by three visits at fortnightly intervals, i.e. six appointments in all, lasting about five minutes each, and totalling 30 minutes over 2 months.
- Using a carbon monoxide monitor, reinforce advice to quit by showing that the level of exhaled CO drops to normal within 24 hours of stopping smoking – a powerful positive-feedback effect!
- Discuss progress and problems, maintain a positive attitude and encourage when despondent.
- Differentiate between a slip (one or two cigarettes) and a relapse (going back to smoking on a regular basis).
- If at first you don't succeed – quit, quit again
- Further help: refer to smoking-cessation clinic

IN CONCLUSION

- Giving up smoking is probably the biggest single thing smokers can do in their life to improve their health.
- Your intervention will probably be the most important single influence you can have on their health.

Are YOU setting an example?

- No-smoking policy in clinic
- No-smoking signs & literature

Remember your "FOUR A's"

1. ASK about smoking
2. ADVISE stopping
3. ASSIST in quitting
4. ARRANGE follow-up

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Help your patient stop; British Medical Association, London, UK, 1988

How to help your patients stop smoking; National Cancer Institute, Bethesda, Maryland, USA, 1990

How you can help patients stop smoking; US Department of Health and Human Services, 1989

It can be done: a smoke-free Europe; Report of the First European Conference on Tobacco Policy, Madrid, 7-11 November, 1988

Quit & Win; Dr Penny Ross and Sandi Wilson, Health Education Authority & BBC Education, 1990

Setting up and running a stop-smoking clinic: Dr Chris Steele, Medical Forum Educational Supplement No 5, 1987

Stopping smoking – How physicians can help patients to quit; Dr Chris Steele, CardioTopics, 1991

Taf x'jagħmillek it-tipjip? ... Aqra ftit; Health Education Unit, Dipartiment tas-Saħħa

The Physician's Role – Three modules on tobacco for national medical associations – Smoke-free Europe:1; WHO Regional Office for Europe, Copenhagen, Denmark, 1987

Trid tieqaf tpejjep? Ara kif ...; Health Education Unit, Dipartiment tas-Saħħa

X'nistgħu nagħmlu flok li npejpu; Health Education Unit, Dipartiment tas-Saħħa.

TUBAL DISEASE

The incidence of tubal disease in an infertile population varies worldwide. In the UK it is estimated at 15%, in Singapore 11.7% while in Cameron 88% (Hull M.R. et al, 1985).

In the UK there are about 8,500 new cases of tubal disease per year.

The common causes are:

- Gonorrhoea
- Tb
- Bacteroides
- Other bacteria
- Chlamydia: 50% tubal disease in Europe (Westran L., Mardh P.A. 1983)
- Mycoplasma
- Post-pregnancy: puerperal sepsis
- IUCD
- Post surgical

The association of IUCD with infertility is good enough reason to make it a contraindication to use it in nulliparous patients.

The incidence of PID in multips who use an IUCD as compared to the pill is 1.8:1. The incidence is five times higher in similar groups of nullips; i.e. the incidence of PID in nullips who use the IUCD as compared to those who use the pill is 5:1.

About 78% of patients with tubal disease will have had previous surgery – In 16% of these, it is an appendicectomy. Other procedures are salpingectomy for ectopic pregnancy, curettage and ERPC's.

20% of patients undergoing wedge resection will develop tubal problems. Ventro suspension performed for retroversion, which is associated with infertility may itself cause tubal disease.

INVESTIGATION OF TUBAL DISEASE

Tubal patency may be assessed by either hysterosalpingography or laparoscopy and dye. Air insufflation (Rubin's Test) is no longer performed since it can cause air embolism.

75% of HSG reports will be correct while 25% will be either false-positive or false-negative. The test is of tubal patency but will say nothing about tubal motility.

Laparoscopy is best performed as the motility of the tube, especially of the fimbrial end, over the ovary, can be assessed.

Endometriosis can further be diagnosed and if a corpus luteum is seen the punctum indicating that our egg has been released, should be identified.

TREATMENT

Primary PID, should be accurately diagnosed by laparsocopy (Pearce M.J. 1990) and treated vigorously with antibiotics to prevent residual disease as much as possible.

The place of tubal surgery has been re-evaluated with many opting for IVF as a first option, this being possibly an overall more cash effective approach besides patient discomfort and anxiety (Lilford R.J., Watson .J., 1990).

However until IVF is more widely available, tubal surgery will continue to be practised especially for reversal of sterilisation. The results will depend much upon patient selection.

Overall results of tubal surgery (Winston R.)

Salpingolysis	25 - 35%
Salpingostomy	20 - 25%
Tubal reimplantation	40 - 15%
Tubal re-anastomosis	30 - 70%
Cornual block	30%
Reversal of sterilisation	
Microscopic	90%
Macroscopic	70%

CERVICAL FACTORS

The investigation of cervical factors as a cause of infertility is by the following tests:

1. Postcoital test
2. Crossed Hostility test
3. Antisperm antibodies

The W.H.O. definition of a positive PCT is when 15 or more active sperm per highpower field are present. It is negative if there are five or less.

If there are no sperm at all, not even dead ones, one should suspect that no intercourse took place or no normal sexual intercourse.

A Crossed Hostility test or formal sperm penetration test (Kremer, 1968) should be performed in the event of a negative PCT.

Method: The couple are advised to avoid sexual intercourse for 3 days and after that a separate sample of husband's semen and wife's mucous are obtained.

These are tested seperately in the following combinations:

1. Husband vs wife
2. Husband vs fertile donor (mucous)
3. Male fertile donor sperm vs wife's mucous
4. Fertile male donor sperm vs fertile female donor mucous

In a local hospital setting a husband sperm / wife mucous challenge is enough. The preparation is observed over a 20 minute period and the formation of a Phalenx as the sperm ascends through the mucous.

Where the Kremer test is abnormal anti-sperm antibodies should be sought in both serum and semen samples. Cervical factors are responsible for about 3% of cases of infertility (Hull M.R. et al, 1985).

Endometriosis

Endometriosis is present in 10 - 15% of premenopausal women undergoing gynaecological surgery and about 25% of premenopausal women will have evidence of endometriosis if this is lokked for. The discrepancy is because the behaviour of endometriosis is highly variable. The diagnosis of endometriosis depends on direct inspection of the peritoneum, not on history and examination and laparoscopy is therefore mandatory.

Endometriosis is found to be the cause in 6% of infertile couples.

Using a wieghted point system, the American Fertility Society (1985) has proposed a classification system which distinguished a minimal, mild-moderate and severe stage of the disease.

The association between infertility and endometriosis is not straightforward except in cases where there is anatomical distortorsion of the pelvic organs.

The management of endometriosis may be either medical, by hormone therapy or surgical.

Hormone therapy aims at suppressing ovarian activity and therefore withdrawing the stimulus for the endometriostic tissue i.e. a pseudo pregnancy or pseudo-menopause.

A pseudo-pregnancy state can be created by either oral contraceptive or progestins (most of the experience being with medroxy-progesterone acetate) while a pseudo-menopause is induced by danazol, gestrinone or LHRH agonists.

Withdrawal of the hormone therapy may however be associated with re-activation of the disease. Furthermore fertility is postponed while on treatment. Surgical treatment is therefore to be considered more definitive treatment but this must be meticulous and excision of all dressed tissue is necessary. For infertile patients laparoscopic surgery is better than laparotomy as it is less likely to cause post-operative pelvic adhesions and tubal occlusion than laparotomy (Sutton C., 1990).

Simple endometriotic spots visualised at laparoscopy may be easily and definitely treated by simple diathermy or better still be laser vaporisation.

Unexplained Infertility

10-15% of couples attending a clinic will be labelled as suffering from unexplained infertility. The possible underlying pathology in these cases include:

1. Anatomical Causes

   (a) a combination of uterine retroversion and low sperm count may lead to difficulty to conception. The treatment is not ventro-suspension but A.I.H.

   (b) kinking-tube syndrome: the incidence of pregnancy in this group is small. It is suggested that it may be due to old PID. The tube is either S or snake shaped.

   (c) abnormalities in physiological oocyte pick up e.g. a non-mobile fimbrial end.

2. Abnormalities of Follicular Growth

3. Abnormalities of the oocyte

4. Luteinised unruptured follicle: even in the presence of a punctum, the ovary could still be trapped inside

5. Abnormalities of the Luteal Phase: a short luteal phase is one that is 7 - 9 days long. The serum progesterone rises in normal patients

6. Immunological causes

7. Psychological factors

Results of Treatment

As a result of treatment about 18% of infertile couples can be expected to conceive (Lifford R.J. and Daltur M.E., 1987). Half the couples presenting with one year infertility can expect to become pregnant spontaneously in the following year.

Table II shows the two year conception rates (Hull Mr et al, 1985).

Causes	
Failure of ovulation:	
Amenorrhoea	96%
Oligomenorrhoea	78%
Tubal damage	19%
Sperm defects	0.27 %
Unexplained	72%

The cumulative success rates of treatment if only one abnormal factor is present is 65% and by 4 years the maximum rate is achieved.

With two factors, the success rate falls to 50% and with 3 factors, if correctable, the success rate is only a little laser by 4 years

Assisted Reproduction

In-Vitro Fertilisation

IVF was originally developed for the treatment of patients with tubal disease but has since found an ever increasing application especially in cases of male infertility (Hewith et al, 1987).

A number of factors are generally considered when selecting patients for IVF, though many may be further discussed in individual cases.

The main selection criteria include

- Age - not generally suitable for patients over 40 years
- Pathology - failed surgery/ idiopathic infertility/ suspected male infertility
- Parity - proven gametes
- Religion
- General Health
- Weight - especially overweight
- Frozen pelvis on pelvic examination

Now that most units perform ovum pick-up by trans-vaginal ultrasound, the presence of contra-indications to laparoscopy (eg abdominal scars) are no longer relevant.

Cases not considered suitable for IVF methods:

- Anovulation
- Uterine fibroids, hypoplastic uterus, cervical stenosis
- Azospermia, successful fertilisation can occur in cases of extreme oligoasthebospermia (<0.5 x 10 motile spermatozoa/ml).

Procedure:

In order to obtain a large number of ova the ovaries are stimulated with clomiphene and Pergonal or Metrodine (FSH).

Follicular development is followed up on ultrasound in combination with serial serum oestradiol estimation.

32 hours after the HCG/LH ovulation dose, ovum retrieval is undertaken. This is usually by transvaginal ultrasound. Prior to insemination the semen sample is prepared by the swim-up technique selecting the most mobile portion. In cases of male infertility the use of split-ejaculates produce a relatively spermatozoa rich first fraction.

If fertilisation occurs, embryo transfer is performed 4.8 hours after insemination, usually at the 4-cell stage, by the trans-cervical vente.

Up to 3 embryos may be replaced per cycle (R.C.O.G., 1990). The luteal phase may be supported either by HCG or progesterone. With the introduction of LHRH agonists (eg Buselerin) used to down regulate the pituitary-ovarian axis, subsequent stimulation is more synchronous with more better quality one.

In cases of male infertility the pregnancy rates ranges from 11 to 23% the lowest fertilisation rate being obtained in cases of oligoasthenospermia. IVF has been shown to be superior to intra uterine AIH.

Micro-manipulation of spermatozoa and occytes may make it possible to treat patients who do not at present benefit from conventional IVF.

The report of the last Interim Licensing Authority (1988) showed the overall pregnancy rate to be 12.9% per treatment cycle and the take-home baby rate 9.1% (Interim Licensing Authority, 1990).

The introduction of IVF in 1975 opened the way for other methods of assisted reproduction and 6 years later Asch et al reported the first pregnancy following translaparoscopic gamete intrafallopian transfer i.e. GIFT.

As another method of assisted reproduction GIFT requires the same ovarian stimulation and ovulation induction as IVF as well as semen preparation. Laparoscopy remains essential in this procedure unlike IVF where oocyte retrieval is now largely by transvaginal ultrasound.

The main steps in a GIFT programme are:

- Induction of multiple follicular devcelopments: clomiphene, HMG, FSH and LHRH agonists.
- Monitoring of follicular developments, ultrasound and oestradiol levels.
- Ovulation induction, HCG is given 24-30 hours after the last dose of HMG to stimulate an LH surge.
- Oocyte recovery: 34-326 after HCG
- Semen preparation: 2-2 1/2 hours before oocyte recovery

GIFT selected eggs together with the sperm preparation are loaded into a catheter into the fimbrial ostium and expelled into the ampulla.

Luteal phase support.

Outcome - menes - biochemical pregnancy (+ve ß-HCG only) or pregnancy confirmed by ultrasound.

GIFT was originally developed for patients suffering from unexplained infertility when one or more aspects of the reproductive process may be defective (Wang P.C. and Asch R.H., 1989) . The process of fertilisation in GIFT is left undisturbed and therefore provides an alternative for patients with normal tubes.

Indications for GIFT (Wang P.C. and Asch R.H., 1989)

- Unexplained infertility
- Endometriosis
- Male factor
- Cervical or Immunological Factor

Failed AID
Premature ovarian failure
(oocyte donation)
Periadvexal adhesion

Patients with previous failed AID achieve high success rates with GIFT; this may be due to the fact that the defect in these patients is either one of sperm transport or of oocyte expulsion or pick-up.

As with IVF the most important complication of GIFT is multiple pregnancy. With the improvement in quality achieved using LHRH agonists high-order multiple pregnancy is a greater problem with its consequent increased incidence of fetal wastage (abortion and prematurity). Except in special cases oocytes (GIFT) and embryo (IVF) replacement should be limited to 3 (Interim Licencing Authority, 1990).

Another important complication resulting from ovarian stimulation is ovarian hyperstimulation which in its severe form is associated with large ovarian cysts, ascites and pulmonary effusions, electrolyte imbalance and coagulation defects.

GIFTS has been proposed as a diagnostic procedure for infertility i.e. at the first laparoscopy for infertility (Abdilla H. et al, 1990) perform also a GIFT cycle thereby minimising the number of procedures and maximising on the possible benefits.

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During its early development the earth's atmosphere was, in chemical terms, a reducing environment and produced an abundance of ferrous iron which therefore became the form used in early biological molecules. Later, increasing amounts of oxygen became available, iron converted to the ferric form and organisms had to evolve various mechanisms to utilize it. Bacteria synthesise high-affinity chelating agents to extract iron from their surroundings; plant roots exude a substance which facilitates iron absorption; while mammals have evolved a specific "shuttle" protein – transferrin – in the upper intestinal tract. These mechanisms work well for bacteria, plants and many mammals, but humans appear to have difficulty in maintaining an adequate iron balance. Besides iron, erythropoiesis requires an adequate regular supply of other nutrients, notably folate and vitamin B12. The relative deficiency of these minerals and nutrients results in various forms of anaemia.

Anaemia, defined as a diminished capacity of the blood to carry oxygen, can be the result of a reduction in either the number of erythrocytes or the haemoglobin content, or in both combined. The symptoms and signs include tiredness, giddiness, headache, palpitations, angina, shortness of breath, oedema and pallor. The aetiological classification of anaemia is set out in Table 1. An important proportion of anaemias are deficiency anaemias, dependent directly or indirectly on nutritional deficiencies of iron, folate, and vitamin B12.

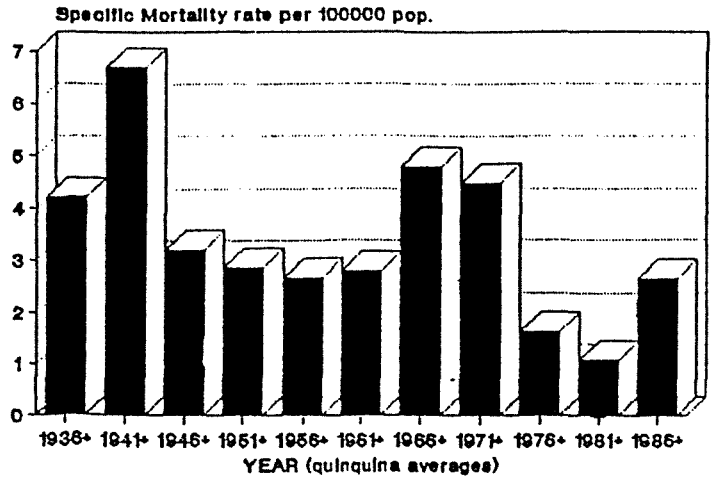
Nutritional anaemia is not a disease entity, it is rather a syndrome caused by malnutrition in its widest sense. WHO has defined it as "a condition in which the haemoglobin content of the blood is lower than normal as a result of a deficiency of one or more essential nutrients, regardless of the cause of such deficiency" (WHO, 1972). Anaemia is the end-result of severe nutrient deficiency of one or more hemopoietic factors, usually iron, less frequently folate or vitamin B12. Haemoglobin concentration, by which anaemia is diagnosed, is a relatively insensitive index of milder degrees of nutrient depletion, so that by the time a person becomes anaemic, there is already a marked degree of nutrient deficiency. The diagnosis of anaemia poses a number of problems, chief among them being the problem of defining what is "normal haemoglobin concentration". The norms below which anaemia or deficiency should be considered to exist are laid down in Table 2.

Nutritional anaemias are related to the social and economic circumstances of the population. They are thus an important problem in underdeveloped and developing countries, particularly in women of reproductive age and children. The proportion of women with a haemoglobin concentration below the norm is related to the GNP of the country/region. In Asia and Africa, regions with low GNP's, the

Table 1
The aetiological classification of anaemia

- ❑ Deficient production of erythrocytes
  - ◆ Iron deficiency
  - ◆ Cyanocobalamin (vit B12) deficiency
  - ◆ Folic acid deficiency
  - ◆ Myxedema
  - ◆ Ascorbic acid (vit C) deficiency
  - ◆ Disorders oferythropoiesis in the marrow
    - ◆ apalastic anaemia
    - ◆ malignant invasion
    - ◆ toxic effects of drugs, infection, uraemia
- ❑ Excessive loss of erythrocytes
  - ◆ Haemorrhage
  - ◆ Abnormal haemolysis
    - ◆ congenital defects (hereditary spherocytosis, thalassaemia, G6PD deficiency)
    - ◆ acquired causes

Figure 1 - SPECIFIC MORTALITY RATES FOR ANAEMIA



Sources: Dept. of Health, 1936-60; Cent Off Statistics, 1961-90

Table 2:
Diagnostic Criteria for Anaemia (WHO, 1972)

CHILDREN:	
6 months - 6 years	11.00 g/dl
6 - 14 years	12.0 g/dl
ADULTS:	
Males	13.0 g/dl
Females	
– non-pregnant	12.0 g/dl
– pregnant	11.0 g/dl

percentage of anaemic women was estimated at 58 and 40% respectively. In Latin America, with a moderate GNP, 17% of women were estimated to be anaemic. On the other hand, European countries were shown to have a incidence of anaemia amounting to 4-7%, while the USA and Australia has incidence rates of 6 and 5% respectively (WHO, 1979). There has been in the latter part of the twentieth century a marked improvement in the socio-economic and health status of the Maltese community. In 1952 it was commented that rickets was frequent enough in the Maltese population to justify enquiry, and efforts were initiated to supplement the diet of school children by the free distribution of milk. It was further commented that it was to be regretted that commercial propoganda focussed on the importance of vitamins and calcium, but neglected iron requirements – a mineral too often very badly needed by Maltese multiparous women and their offspring (Galea, 1954). The deficiency disorders remain a cause of population mortality (Figure 1).

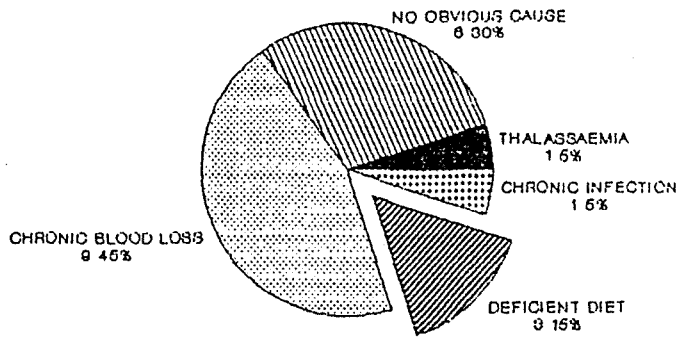
The social and health situation on the Maltese Islands improved in subsequent years. In the late 1960's a preliminary epidemiological study showed that the haemoglobin levels in both sexes fell within the normal range being above 12.8 g/dl in males and 12.2 g/dl in females (Fenech et al, 1970). The mean haemoglobin levels of 292 male donors were shown to approximate 14.0 g/dl, while in 41 female donors the level was lower at 12.7 g/dl (Schembri Wismayer and Gingell, 1970). Haemoglobin levels below 13 g/dl were found in 29.6% of adult males, while anaemia was identified in 2.9% of newborns who had a mean haemoglobin of 16.0 g/dl (sd 2.6) (Felice, 1975). Women of child bearing age were shown to have a mean haemoglobin level of 13.6 g/dl, a figure similar to those reported from other countries at the time:

United Kingdom	13.8 g/dl
Norway	14.1 g/dl
Canada	13.8 g/dl
Israel	12.4 - 12.8 g/dl

(Fenech, 1968).

The haemoglobin value did not appear to be markedly influenced by age, but there appeared to be a direct positive correlation between grand multiparity and haemoglobin level. The incidence of a low haemoglobin (under 12 g/dl) in the screened population was 6.2% in married women and 4.5% in unmarried women. The causes identified for the low haemoglobin in 20 patients are outlined in Figure 2 (Fenech, 1968). The mean haemoglobin level of 140 pregnant women was estimated at 11.56 g/dl (sd 3.92) at 24 weeks and 12.93 g/dl (sd 3.61) at 34 weeks gestation (Schranz, 1986).

Figure 2 - CAUSES OF ANAEMIA IN MALTESE FEMALES: 1966
Hb < 12 g/dl



Source: Fenech, 1968

Figure 3 - CAUSES OF PREGNANCY ANAEMIA: 1968 & 1990

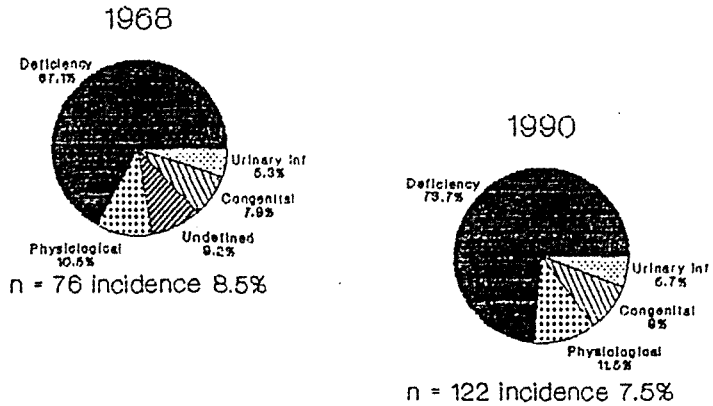
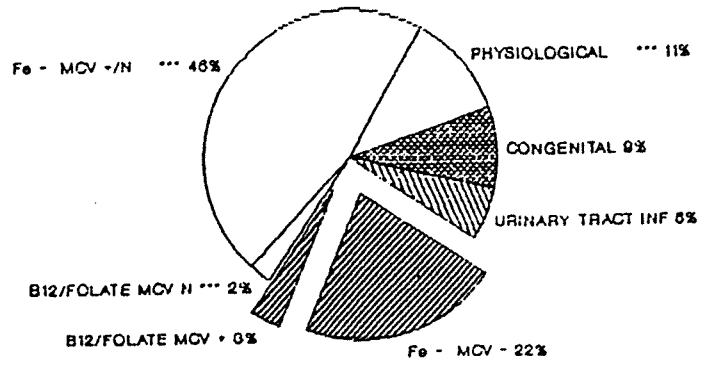


Figure 4 - PREGNANCY ANAEMIAS – REVISED DEFINITIONS
*(*** normal MCV: probably physiological)*



The incidence of anaemia in Maltese pregnant women, defined as a haemoglobin level of less than 11 g/dl, was estimated in 1968 to account for 8.5% of the screened population. About 40% of women were receiving haematological supplements at the time of screening. The incidence of anaemia appeared to be higher in women not receiving haematologicals than in women who received iron supplements (Table 3). Grand multipara had a significantly lower haemoglobin ($p<0.001$) and packed cell volume ($p<0.01$), than women of a lower parity. There was no association with maternal age (Benster, 1968). The causes of anaemia were identified to be caused by deficiency anaemias in 67.1% of cases (Figure 3), these being accounted for by iron deficiency in 56.6% and possible folic acid deficiency in 10.5%. It is well established that dietary iron is barely sufficient to meet the requirements of pregnancy, and deficiency is likely to occur if there is any additional predisposing factor. The anaemic pregnant patients were shown to have had a greater incidence of menorrhagia before pregnancy, gastro-intestinal disorders, haemorrhoids and bleeding gums. It was also found that the intake of meat was less frequent in anaemic patients (Benster et al., 1969). Higher figure were reported by Felice who found 25% of pregnant females to have a haemoglobin less than 11 g/dl (Felice, 1975). In 1990, the incidence of pregnancy anaemia in Maltese women was established at 7.2%, with nutritional anaemias accounting 73.7% of the patients with a low haemoglobin (Zammit, 1991). This high 1990 incidence of nutritional anaemias defined with the same criteria used in 1968 was reported irrespective of the high proportion of haematological and nutritional prescriptions used in the Maltese pregnant population. The Drug Use in Pregnancy Study in 1987 showed that 92% of women received iron supplements during their pregnancy, while a further 28% received nutritional supplements. The haematological supplements were generally prescribed by the second trimester (Savona-Ventura and Grech, 1990).

The incidence of a low pregnancy haemoglobin appears to have decreased during the twenty year period of the two surveys from 8.5% in 1968 to 7.2 % in 1990, though the difference was not statistically significant ($p>0.1$). The decrease was mainly in the number of patients with severe anaemia (Hb <10 g/dl) when the incidence fell from 2.7% to 1.8%. The incidence of a mild anaemia (Hb 10-11 g/dl) only decreased from 5.8% in 1968 to 5.4% in 1990. The causes for the anaemia showed little difference between the two study groups (Figure 3). Deficiency anaemias in 1968 accounted for 67.1% and 73.7% in 1990, while physiological anaemia of pregnancy accounted for 10.5% and 11.5% respectively. Congenital anaemias (mainly thalassaemia trait) accounted for 7.9% and 9.0% respectively, while urinary tract infection accounted for 5.3% and 5.7% respectively. There were 9.2% of cases in 1968 where the cause for the low haemoglobin was not identified, and this alone could have accounted for the differences noted. The reported incidences of pregnancy anaemia vary from one country to another depending on the social circumstances of the country. In developing countries, deficiency anaemia may account for up to 50% of pregnancies (Table 4).

Table 3:
Incidence of Pregnancy Anaemia by haematological use
(Benster, 1968)

Hb level	untreated	treated	TOTAL
<10 g/dl	3.25 %	1.75%	2.7%
10 - 11 g/dl	7.5 %	3.5 %	5.8 %
< 11 g/dl (total)	10.75 %	5.25 %	8.5 %

Table 4:
Incidence of pregnancy anaemias (Hb<10 g/dl): 1953-1968 (Benster, 1968)

Malta		**2.7%**
United Kingdom:	**London (East End)**	**9.0%**
	Aberdeen	**2.4%**
Ireland (Dublin)		**31.4%**
USA (Louisiana: low income group)		**20.0%**
China (Hong Kong)		**14.5%**
Australia		**3.0%**
Israel (Jerusalem)		**6.9%**
S. Africa (Pretoria: Bantu)		**2.0%**
Trinidad		**34.0 %**
India (Vellore)		**40.0%**

Deficiency anaemias in the Maltese population appear to be a common problem during pregnancy, apparently accounting for 67-74% of all cases of anaemias. However in spite of the improvements in the social, economic and biological status of the population, and changes in the prescribing habits over the last twenty years, there has been little or no significant change in the incidence and type of pregnancy anaemia in Maltese pregnant women. These observations suggest that anaemias due to nutritional deficiencies are rare in the Maltese Islands, and deficiency anaemias are predisposed to by previous chronic blood loss. Furthermore the problem remains that the definitions used to identify deficiency anaemias in pregnancy must incorporate the physiological changes that are known to occur during pregnancy. A substantial proportion of cases defined as deficiency anaemias on the basis of a low ferritin, folic acid or vitamin B12 were shown to have normal mean corpuscular volumes suggesting these cases to be "physiological anaemias of pregnancy" caused by hypovolaemia.

These corrections would suggest that physiological anaemia of pregnancy may account for 59% of all cases with a haemoglobin less than 11 g/dl, while deficiency anaemias account for only 25% of cases (Figure 4)

In view of the data which suggests that less than a hundred women annually suffer from deficiency anaemia during pregnancy one must question the usefulness of routinely prescribing haematological supplementation to all women in a population with a good socio-economic status. These supplements should be reserved for women shown to have specific deficiency disorders, especially considering the gastro-intestinal side-effects of these drugs (Zammit and Savona-Ventura, 1992).

Congenital anaemias in the Maltese population are an important aspect of the problem. Beta-thalassaemia trait has been reported to occur in about 4% of the Maltese population, the prevalence being reportedly higher in Gozo than in Malta, and accounts for about 20% of anaemias in Malta (Vella, 1962; Cauchi, 1970; Felice, 1975), though recent studies in the pregnant female population suggest a prevalence of about 1% (Zammit et al, 1991). In addition the Maltese population has been found to have fatal haemoglobin varianta with an incidence of about 2% (Cauchi et al, 1969; Bannister et al, 1972; Felice, 1975), but these have no reported haematological significance since only heterozygous carriers have been described. Glucose-6-phosphate dehydrogenase deficiency has been shown to affect 2.7% of adult males and 1.9% of adult females (Cauchi and Grech, 1968). In infants partial deficiency accounted for 5.8% of males and 4.2% of females, while total deficiency was reported in only 1.5% and 0.4% respectively (Grech and Vicatou, 1973). In pregnancy Beta-thalassaemia was shown to be present in 17.8% of women having a haemoglobin less than 11 g/dl and in 8.8% of women with a haemoglobin less than 12 g/dl (Felice, 1975). The problems of thalassaemia and other congenital hemolytic disorders in pregnancy in Maltese pregnant patients have been previously reviewed (Grech et al, 1984; Savona-Ventura and Grech, 1991; Savona-Ventura, 1992; Kim, 1979).

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E.C. Research fellowships in general practice

The European Community has agreed to fund, as part of the Human Capital and Mobility programme, a number of research fellowships in primary care.

Fellowships are open to medical and non-medical graduates from Europe (resident outside the UK) and will be based at the Department of Primary Care at the University of Southampton. Attachment to the Department of Public Health and Primary Care at the University of Oxford may also be possible.

Two types of fellowship are offered:

Training Fellowships

These will be of 12 months duration and fellows will be helped to undertake original research preferebly in liason with a primary care research organisation in their home country. It is hoped that they will become involved in the European "Cochrane" initiative in primary care.

Senior Fellowships

These will be for up to 3 months duration and are for research workers of senior lecturer or professorial status to facilitate exchange of ideas and expertise.

Fellowships will cover the cost of return travel to the UK. Training Fellows will be paid a flat rate of 3,800 ECU (about £2,600) per month. Senior Fellows will be reimbursed for travel and living expenses at a rate to be negotiated with the Commission. Fellowships must be taken up between 1994-6. It is hoped to appoint 3 Training Fellows and 4 Senior Fellows during this period.

Informal expressions of interest are encouraged and should be made as soon as possible, to:

Dr David Mant,
University Department of Public Health and Primary Care,
Gibson Building, Radcliffe Infirmary,
OXFORD, OX2 6HE, United Kingdom,
Tel: 44-865-319125 Fax: 44-865-511635

or

Professor Ann-Louise Kinmonth,
Department of Primary Medical Care,
Aldermoor Health Centre, Aldermoor Close,
SOUTHAMPTON, SO1 6ST, United Kingdom
Tel: 44-703-783111 Fax: 44-703-701125

Day 1: **20 January**

Telling patients the truth - Dr Denis Soler
How I manage ... - Dr Mario Cilia

Number of evaluation forms returned: 36

Status:

College member	31
Other registered doctor	2
No reply	3

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

Agree strongly	14
Agree	21
No reply	1

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

Agree strongly	5
Agree	27
Undecided	1
Disagree	3

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

Agree strongly	2
Agree	25
Undecided	3
Disagree	5
No reply	1

The best feature of today's seminar was:

- *Telling patients the truth* (*3)
- *How I manage ...* (*10)
- Equally interesting
- General interest
- Great relevance to family practice
- The discussion of both parts as it stimulates members to participate actively
- Topics were more practical and more common everyday situations than in previous lectures

Today's seminar would have been better if:

- Started on time
- It did not start 15 minutes late
- No – good enough
- More clinical points
- Dr M Cilia's lecture had overheads
- First talk was more wide-based – dealing with more than one clinical setting
- We have the option of specialists (e.g. gynaecologists / counsellors) for *How I manage ...*

Day 2: **21 January**

When do I need physiotheraphy - Ms M Muscat
What I've learnt - Case presentation - Dr J. Pace

Number of evaluation forms returned: 41

Status:

College member	33
Other registered doctor	2
No reply	6

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

Agree strongly	7
Agree	33
Undecided	1

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

Agree strongly	3
Agree	32
Undecided	5
Disagree	1

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

Agree strongly	1
Agree	30
Undecided	5
Disagree	4
No reply	1

The best feature of today's seminar was:

- *When do I need phsiotheraphy* (*5)
- *What I've learnt - case presentation* (*12)
- The second part of the case presentation
- Good - we started on time
- Both subjects were very relevant to family practice
- Encourage more How I manage ... talks - it proved to be very illuminating
- The stress on what physio's can do, and Dr J Pace's moral warning to take extra extra care of all patients

Today's seminar would have been better if:

- Visual aids were used by Ms Muscat
- Dr Pace had tried putting his X-ray and other films on the overhead projector
- Talk on physiotheraphy could have been more informative
- Another talk on methods used in physiotherapy for ???? conditions
- Perhaps a physiotherapist with more experience of types of GP referrals would have been better

Day 3: **22 January**

Epidemiology and early detection of common cancers - Dr Herbert Sultana

Number of evaluation forms returned: 37

Status:

College member	30
Other registered doctor	3
Other	2
No reply	2

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

Agree strongly	12
Agree	22
Undecided	2
No reply	1

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

Agree strongly	4
Agree	26
Undecided	3
Disagree	2
No reply	2

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

Agree	21
Undecided	5
Disagree	6
Disagree strongly	1
No reply	4

The best feature of today's seminar was:

- Presentation format, visual aids
- Mode of presentation: very concise and to the point
- All of it
- Ca detection
- Recent statistics
- Good overview of local situation
- Value of epidemiology in study of cancer
- The two 5-year group incidence rate and interesting figures shown

Today's seminar would have been better if:

- Microphones to be available to all speakers including the audience
- The role of family doctors in early detection could be practically highlighted
- Early detection methods rather than statistics were presented in this lecture
- Basics of notification, denominator data, difference between incidence and prevalence, i.e. some basic epidemiological principles.

Please suggest topics for our future CPD meetings:

Day 1

- Infectious diseases of childhood
- Experiences of older GP's
- Prescribing in pregnancy
- More on dermatology
- Ask Ray!

Day 2

- I think it would be good to have a lecture more in detail about the basic principles and the methods actually used in practice
- Well-Baby Clinics: the Malta set-up, a means of keeping children away from the family doctor
- Basic principles of ECG

Day 3

- Recent advances
- "Accouchers in Malta" – why have they excluded family doctors from ante natal care?
- This seminar should be followed with one dealing with modern development in multidisciplinary treatment of various forms of cancer.

Renewal Of Subscriptions
Call For Speakers

Members are reminded to renew their subscriptions for 1994
and to come forward to deliver a paper at one of the College's CPD programmes

Day 1: **5 May**

Mental Health Legislation and the Family Doctor - Dr Joseph R Saliba
A lesson I have learnt - Dr Anthony Felice

Number of evaluation forms returned: 23

Status:

College member	21
Other registered doctor	1
No reply	1

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

Agree strongly	4
Agree	19

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

Agree strongly	3
Agree	17
Undecided	1
Disagree	2

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

Agree strongly	1
Agree	14
Undecided	3
Disagree	4
No reply	1

The best feature of today's seminar was:

- *Mental Health Legislation and the Family Doctor* (*5)
- *A lesson I have learnt* (*5)
- Both were good
- The proper use of forms on admitting to MCH
- Enjoyed Dr Felice's case presentation enormously
- Dr Felice's 10 minute personal talk (experience)

Today's seminar would have been better if: (NIL)

Day 2: **6 May**

Dietary Advice to Patients - Mr Godfrey Xuereb
How I manage ... - Dr Anne Marie Said

Number of evaluation forms returned: 25

Status:

College member	16
No reply	9

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

Agree strongly	10
Agree	13
Undecided	1
No reply	1

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

Agree strongly	8
Agree	15
Undecided	1
Disagree	1

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

Agree strongly	5
Agree	16
Undecided	2
Disagree	2

The best feature of today's seminar was:

- *Dietary advice to patients* (*5)
- *How I manage* (*1)
- Both were good
- New awareness in dietetics
- Professionalism showed by the dietician
- Very informative talk by the nutritionist
- Dietary management of non-communicable diseases
- Difficult clinical scenario which was well-tackled
- Discussion after talks: this should be encouraged and prolonged

Today's seminar would have been better if:

- Started on time
- More time for first talk
- Topic A restricted scope
- It had more information on a diabetic diet
- A panel discussed the hepatitis case

Day 3: **7 May**

Recent advances in the treatment of common cancers - Dr Victor Muscat

Number of evaluation forms returned: 17

Status:

College member	17

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

Agree strongly	7
Agree	8
Undecided	2

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

Agree strongly	8
Agree	9

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

Agree strongly	4
Agree	10
Undecided	1
Disagree	2

The best feature of today's seminar was:

- Statistics information
- Trends in cancer death
- Concise awareness of the recent therapy of cancers
- New emphasis on quality of life for our cancer patients
- Latest management of breast tumours especially regarding the fact that mastectomy is now very limited compared to what we were taught only 12 years ago

Today's seminar would have been better if:

- More family-medicine oriented

Please suggest topics for our future CPD meetings:

Day 1

- The overuse of sedatives in general practice

Day 2

- Prescribing in pregnancy
- How about some debate?

Day 3

(No suggestions)

cpd

Evaluation Of The Autumn 1993 CPD Meeting

Day 1: **6 October**

A specialized unit in Geriatric Medicine: Zammit-Clapp Hospital - Dr Anthony Fiorini
A lesson I have learnt - Dr Mario Rizzo Naudi

Number of evaluation forms returned: 43

Status:

College member	33
Other registered doctor	7
Houseman	1
No reply	2

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

Agree strongly	10
Agree	33

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

Agree strongly	6
Agree	35
Undecided	1
No reply	1

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

Agree strongly	3
Agree	29
Undecided	4
Disagree	5
No reply	2

The best feature of today's seminar was:

- *A lesson I have learnt* (case presentation) (*13)
- Perseverance in Dr Rizzo Naudi's approach
- I fully agree with the last 3 statements of Dr M Rizzo Naudi
- A lesson I have learnt demonstrates yet again that the consultant is not always right and that the family doctor should stick to his views if the consultant's opinion does not seem to hold water
- Increased awareness of Zammit Clapp's function
- Education to doctors on ZCH services
- Choice of suitable patients for stay at ZCH
- More information on ZCH was made available (*2)
- Administration information
- Both lectures were good/interesting (*7)
- Clarity of delivery
- Prosit both speakers

Today's seminar would have been better if:

- More information on Day Hospital at ZCH
- You will give us the form how to refer to Zammit Clapp
- If the circular regarding the referral of a patient to ZCH was handed out prior to the meeting
- Started on time

Day 2: **7 October**

Managing strokes in the community - Dr Anthony Galea Debono
How I manage ... - Dr Godfrey Farrugia

Number of evaluation forms returned: 58

Status:	College member	40
	Other registered doctor	6
	Houseman	7
	No reply	5
Today's seminar was relevant to family medicine/general practice:		
	Agree strongly	16
	Agree	39
	Undecided	2
	Disagree	1
Today's seminar increased my knowledge and/or awareness of issues:		
	Agree strongly	8
	Agree	46
	Undecided	2
	Disagree	2
My patient care will be modified as a result of this seminar:		
	Agree strongly	4
	Agree	33
	Undecided	10
	Disagree	7
	No reply	4

The best feature of today's seminar was:

- *Managing strokes in the community* (*14)
- *How I manage ...* (*5)
- The importance of referring every CVA patient early to hospital was made clear
- Dr Galea Debono's delivery of subject (*2), and information relevent to FD was excellent
- The impotence feature was very comprehensive
- The talks were very well clinically oriented
- Both lectures were *very* good (*3)
- Short and to the point (*2)

Today's seminar would have been better if:

- Treatment which can be given by GP (for stroke) was discussed further (*2)
- What services available in the community were explained in some detail
- Dr Farrugia's lecture was too "book-copying"
- Slides/overheads in Dr Farrugia's talk (*2)
- More lively
- Handouts provided
- Coffee/tea and biscuits were served
- Increased relevance to family medicine given

Day 3: **8 October**

The general management of the patient with malignant disease - Dr Stephen Brincat

Number of evaluation forms returned: 51

Status:	College member	38
	Other registered doctor	6
	Houseman	4
	Medical Student	1
	No reply	2
Today's seminar was relevant to family medicine/general practice:		
	Agree strongly	11
	Agree	33
	Undecided	4
	Disagree	1
	No reply	2
Today's seminar increased my knowledge and/or awareness of issues:		
	Agree strongly	9
	Agree	35
	Undecided	4
	Disagree	2
	No reply	1
My patient care will be modified as a result of this seminar:		
	Agree strongly	5
	Agree	30
	Undecided	10
	Disagree	6

The best feature of today's seminar was:

- Detailed / interesting visual presentation (including neglected Ca cases) (*5)
- Very clear / informative, well-organised practical presentation (*4)
- Pain control (*2)
- Care of terminally ill patient
- The consultant!
- Eloquence
- Reception (*2)

Today's seminar would have been better if:

- More practical examples were given
- More detail on different cancer pathologies
- More visual material
- Started on time
- It was shorter
- There was more time available
- Better audio - the speaker was at times inaudible at the back (*4)
- Dr Brincat spoke less monotonously on such a depressing subject
- Dr Felice did not chair the session

Please suggest topics for our future CPD meetings:

Day 1
- Dermatology
- GP practice in neighbouring countries – level, materials & organizational methods
- Paediatric topics
- Palliative care
- TB due to increased incidence in the future
- Treatment of chronic and end-stage renal failure in the community

Day 2
- AIDS-related topics
- Care of terminally(-ill) patients
- Child abuse in the community
- Computer records
- Prescribing in pregnancy
- X-ray indications versus ultrasound

Day 3
- Common conditions
- Nutrition
- Trauma

Compiled by: Dr Mario R Sammut MD
Secretary for Research

cpd

EUROPEAN GENERAL PRACTICE RESEARCH WORKSHOP
COPENHAGEN, DENMARK – 5TH - 8TH MAY 1994

THE USE OF CLINICAL STANDARDS AND GUIDELINES IN GENERAL PRACTICE

Call for Papers and First Announcement

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The use of standards or guidelines in general practice is currently considered as an important feature of medical audit and quality assurance. The most important value probably lies in assessing and improving quality of care delivered by general practice. Having said that, many questions arise. What methods exist to develop guidelines? Should guidelines be made for daily practice (performance) or should they be made for educational purposes (competence) only? What properties should methods to develop guidelines preferably have? Is there one method which is best? What is the place of outcome-measures in developing guidelines?

How should guidelines be used in practice, that is do general practitioners have to comply 100% with guidelines or are sub-standard performances acceptable, in other words against which norms/values are general practitioners to be assessed?

From an European perspective use of clinical standards and guidelines in general practice is also very interesting since different countries have different cultures, which influence the choice how to develop and use guidelines in the countries involved.

There have been many papers in international journals related to the theme of this EGPRW meeting, but, the more interesting, the theme is still controversial. Therefore it is our hope that many will submit papers for this meeting in order to show how standards/guidelines are used in particular projects and particular countries and what results have been achieved. The EGPRW welcomes in particular also those who would like to discuss research proposals around standards / guidelines.

As always at EGPRW meetings there is also much space for those who would like to present free-standing papers.

On behalf of the EGPRW we invite you to submit an abstract and hope to see you in Copenhagen.

CLOSING DATE: **15 January 1994**