



it-tabib tal-familja

Qasbi



JOURNAL OF THE MALTA COLLEGE OF FAMILY DOCTORS

ISSUE No.12 JUNE 1997

- Pocket Set of Surgical Instruments
- Honorary Secretary's Report 1996-97
- European General Practice Research Workshop
- IDDM in Malta
- Trends in Preoperative Cardiac Catheterisation in Congenital Heart Disease
- Snoring and Your Health

The power to succeed
in everyday infections.

AUGMENTIN

amoxicillin + clavulanate potassium

Success that rises above resistance.

PRESCRIBING INFORMATION

INDICATIONS

Upper Respiratory Tract Infections e.g. Sinusitis, tonsillitis, otitis media. **Lower Respiratory Tract Infections** e.g. Acute and chronic bronchitis, lobar and bronchopneumonia, empyema, lung abscess. **Skin And Soft Tissue Infections** e.g. Boils, abscesses, cellulitis, wound infections, intra-abdominal sepsis. **Genito-Urinary Tract Infections** e.g. Cystitis, urethritis, pyelonephritis, septic abortion, puerperal sepsis, pelvic infections, chancroid, gonorrhoea. **Other Infections** e.g. Osteomyelitis, septicaemia, peritonitis, post-operative infections. AUGMENTIN intravenous is also indicated for prophylaxis against infections which may be associated with major surgical procedures involving gastro-intestinal, pelvic, head and neck, cardiac, renal, biliary tract and joint replacement surgery.

DOSAGE

Adults and Children Over 12 Years. Oral:- Mild-moderate infections: One 375mg AUGMENTIN tablet three times a day. Severe infections: One 625mg AUGMENTIN tablet three times a day or two 375mg AUGMENTIN tablets three times a day. The 625mg AUGMENTIN tablet is not available in all countries. **IV Injection/Infusion:-** Usually 1.2g 8 hourly. In more serious infections increase frequency to 6 hourly intervals. **Children.** Oral:- Children 7-12 years: 10ml AUGMENTIN 156mg syrup three times a day* or 5ml AUGMENTIN 312 mg syrup three times a day*. Children 2-7 years: 5ml AUGMENTIN 156mg syrup three times a day*. Children 9 months-2 years: 2.5ml AUGMENTIN 156mg syrup three times a day*. Children 0-9 months: No suitable oral presentation is currently available for this age group. *In severe infections these dosages may be doubled. Treatment with AUGMENTIN should not be extended beyond 14 days without review.

CONTRA-INDICATION Penicillin hypersensitivity.

PRECAUTIONS Changes in liver function tests have been observed in some patients receiving AUGMENTIN. The clinical significance of these changes is uncertain but intravenous AUGMENTIN should be used with care in patients with evidence of severe hepatic dysfunction. In patients with moderate or severe renal impairment AUGMENTIN dosage should be adjusted as recommended in the Package Insert Leaflet.

USE IN PREGNANCY AND LACTATION Use of AUGMENTIN in pregnancy is not recommended unless considered as essential by the physician. During lactation, trace quantities of penicillins can be detected in breast milk.

SIDE EFFECTS Side effects, as with amoxicillin, are uncommon and mainly of a mild and transitory nature. Diarrhoea, pseudomembranous colitis, indigestion, nausea, vomiting, and candidiasis have been reported. Nausea, although uncommon, is more often associated with higher oral dosages.

If gastro-intestinal side effects occur with oral therapy they may be reduced by taking AUGMENTIN at the start of meals. Urticarial and erythematous rashes sometimes occur but their incidence has been particularly low in clinical trials. An urticarial rash suggests penicillin hypersensitivity and treatment should be discontinued. Erythematous rashes are frequently mild and transient but may be severe when associated with infectious mononucleosis, in which case treatment should be discontinued. Rare cases of erythema multiforme, Stevens-Johnson syndrome and an occasional case of exfoliative dermatitis have been reported. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions and angioneurotic oedema have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy, it has occurred in patients taking oral penicillins. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens. Hepatitis and cholestatic jaundice have been reported.

AVAILABILITY 375mg AUGMENTIN tablets: White oval film coated tablets engraved "AUGMENTIN" on one side. Each tablet contains 250mg amoxicillin and 125mg clavulanic acid. 625mg AUGMENTIN tablets: White oval film coated tablets engraved "AUGMENTIN" on one side. Each tablet contains 500mg amoxicillin and 125mg clavulanic acid. 156mg AUGMENTIN syrup: Powder for preparing fruit flavoured syrup. When dispensed each 5ml contains 125mg amoxicillin and 31.25mg clavulanic acid. 312mg AUGMENTIN syrup: Powder for preparing fruit flavoured syrup. When dispensed each 5ml contains 250mg amoxicillin and 62.5mg clavulanic acid. In oral presentations amoxicillin is present as the trihydrate and clavulanic acid as the potassium salt. Not all presentations are available in every country.

Further information is available on request to:
SmithKline Beecham International, SB House,
Great West Road, Brentford, Middlesex TW8 9BD, England.

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International

Editorial

Dear Readers,

Very recently, the College has formed a sub-committee to review the action plan for the remaining term of the present Council.

The policy document on Family Medicine in Malta, the document on the Specialist Training Programme and a policy document on Research in Family Medicine are all to be launched in the very near future. To compliment these important documents, the College is preparing a series of informative newspaper articles, TV and radio programmes to familiarise the public with Family Medicine. The format and content of these presentations are still to be defined.

I would like to dedicate this editorial to soliciting contributions from the College members, suitable for these programmes and articles in the papers. Here is a golden opportunity to influence public opinion in favour of General Practice, and yet the task seems daunting when the dozen or so Council members try to tackle the logistics of the exercise alone. The assistance and participation of College members are essential for the success of this strategy.

All members who feel that they can contribute ideas or articles suitable for publication in the lay press, or better still, feel confident to participate in radio or television programmes talking about Family Medicine or related topics should write to me at the College headquarters in St. Philip's Hospital, or e-mail me at jksoler@synapse.net.mt.

The success of this campaign depends on the support of the College members over a long period of time.

It is appropriate that the Launch of these documents is widely publicised and favourably affects public opinion in our regard.

Jean Karl Soler

Editorial	page 1	IDDM in Malta	page 15
Pocket Set of Surgical Instruments	2	A.G. Schranz	
C. Savona-Ventura & J. Thake		Trends in Preoperative Cardiac Catheterisation in Congenital Heart Disease	18
Honorary Secretary's Report 1996 - 97	5	Victor E. Grech	
Mario R. Sammut		Snoring and Your Health	22
European General Practice Research Workshop	9	Adrian M. Agius	
Anthony Mifsud			

Cover Photo taken by J.K. Soler:

Bighi hospital from St. Angelo watchtower. The lift from the sea to the hospital is clearly visible.

INTRODUCTION

The advances in medical care since the post-Second World War period have raised the expectations of patients resulting in changes in doctors attitudes towards management. The performance of minor surgical procedures by general practitioners during home visits are now rarely undertaken. The situation was very much different in the past and many practitioners carried a pocket set of surgical instruments for use during their consultations. An example of such a set is described.

PROVIDENCE

The surgical instruments pocket set belongs to one of the authors (J.T.), having been handed down through an unspecified number of generations by his maternal side of the family (Agius Gilibert).

DESCRIPTION

a: The Instrument Case

The set of surgical instruments is contained in a small carrying case made of red fine leather. The case folds in three main sections and a flap which contained a "spring" clasp used to secure the case. When closed the case measures 155x75x25 mm, when opened the instrument compartment measures 155x225 mm. Each of the three compartments has two flaps which fold over covering the instruments. The case also has a side pocket measuring 155x75 mm and which has a smaller pocket compartment in one of its sides. The instruments are kept in place by a number of leather loops – 3 instrument loops in the first section, 5 loops in the middle section, and 4 loops in the third section.

b: Instruments

The first section holds three instruments including a screw-joint artery forceps without a

restraining clip (total length 135 mm; length of blades 40 mm); a thin trocar (without cannula) set in a small wooden handle (trocar length 40 mm; handle length 65 mm); and a triangular-shaped leather cover, presumably to protect a sharp cutting instrument (height 85 mm; width 25 mm). The Middle section holds five instruments including three bistouries or scalpels which fold into tortoise-shelled handles. The bistouries' blades are marked at the base of the blade by the Royal Crown and the letters STD and DART. (a. straight sharp-pointed – blade length 65 mm, handle length 87 mm; b. straight broad-pointed – blade length 63 mm, handle length 87 mm; c. curved sharp-pointed – blade length

(tip-to-base) 70 mm, handle length (tip-to-tip) 100 mm.

The other instruments in the middle section includes a Schnapper's lancet which folds between two tortoise-shell handles (blade length 55 mm, handle length 73 mm); and a director for probes with a fraenum slit (length 140 mm ends in a side-attached ring 12 mm diameter). The third section holds two probes one ending in a sharp trocar point, the other in an eye (length 130 mm); a Gum lancet which folds in a tortoise-shell handle (blade length 70 mm, handle length 85 mm); a pair of sharp-pointed angled on flat screw-joint scissors (one blade broken) (length 140 mm, blade length 45 mm); and a Pestle which



unscrews from about a third of its length. Its cavity appears coated mildly with yellowish powder. The Side Pocket contains two small lancets for venesection or vaccination; which fold into a tortoise-shell handle (blade length 40 mm, handle length 55 mm); a set of ten triangular cutting-pointed eyed curved needles of various sizes for suturing (min. diameter 35 mm, max. 57 mm); and a paper packet containing bright orange powder of unknown constitution.

DISCUSSION

The described set would allow for the performance of minor surgical procedures including the excision of small superficial tumours, drainage of abscesses or hydrocoeles, management of sinuses, suturing of lacerations, and venesection. It would also facilitate smallpox vaccination via scarification, and also allowed for the preparation of ointments, etc.

A number of medical sets from Malta have been described. These sets were either fully equipped medicine chests for use on naval vessels during the seventeenth century, or fully equipped surgical sets used by the late eighteenth century surgeon Prof. S.L. Pisani. The

provision of a ship's medicine chest was enforced by Maltese law during the time of the Order of St. John. The described chest dated to 1662 contained no less than 55 kinds of medicinal preparations. The instruments in the chest included a pair of tweezers, cupping vessels, and a syringe for performing rectal enemas. There was no mention of lancets, bandages, pestle and mortar, balance, ointment slabs or splints¹. The second set of two instrument cases belonged to Prof. S.L. Pisani. These were bought from Young of Edinburgh and from Weiss of London. These instruments contained a large variety of surgical instruments which allowed the performance of a large number of major surgical procedures including amputations and lithotomies².

Another incomplete nineteenth instrument case is held at the Malta Medical School old instruments collection. The present paper is the first to describe a pocket set of surgical instruments. The selection of instruments contained in the described pocket set dates this to the late nineteenth or early twentieth century, and it probably originated from the United Kingdom. A similar instrument case was still being offered for sale by Allen & Hanburys Ltd of London in 1957.

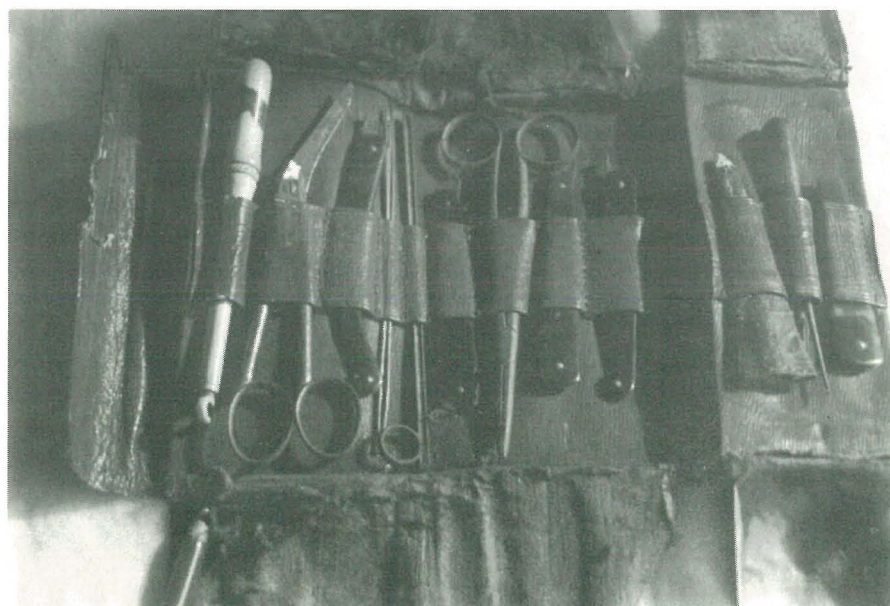
This was made of rexine and had a removable washable lining and 12 loops for instruments. Other variants of pocket cases, constructed from metal, khaki drill or Morocco, were also offered for sale. The contents included two double pocket knives, scissors, dissecting forceps, a Spencer Wells' Artery forceps, a caustic case, a probe with eye, a spatula, and an aneurysm needle and director³.

Pocket instruments sets are still being offered for sale by a number of instrument makers, though these cases are usually made of metal to facilitate sterilization^{4,5,6,7}. Surgical instruments in Malta were not easily available to local practitioners during the nineteenth century.

Occasionally a few surgical instruments were manufactured by Maltese silversmiths, but as late as 1871 private practitioners were not adequately supplied since civilian surgeons are noted to have taken instruments on loan from Bighi Naval Hospital or from the government Civil Hospital. Instruments at the Civil Hospital which became unfit for further repairs were condemned and sold by public auction⁸.

Pocket medical instrument sets were in use during the early nineteenth century, being an essential item carried by army and naval medical officers. The pocket-case of surgical instruments was often the only surgical kit available to the army practitioner in the field since problems in transportation and organization often resulted in medical stores not reaching the field. Thus Surgeon Thomas Longmore of the Green Howards Regiment during the Crimean War landed at Calamata Bay to find that his medical provisions had been returned to Malta.

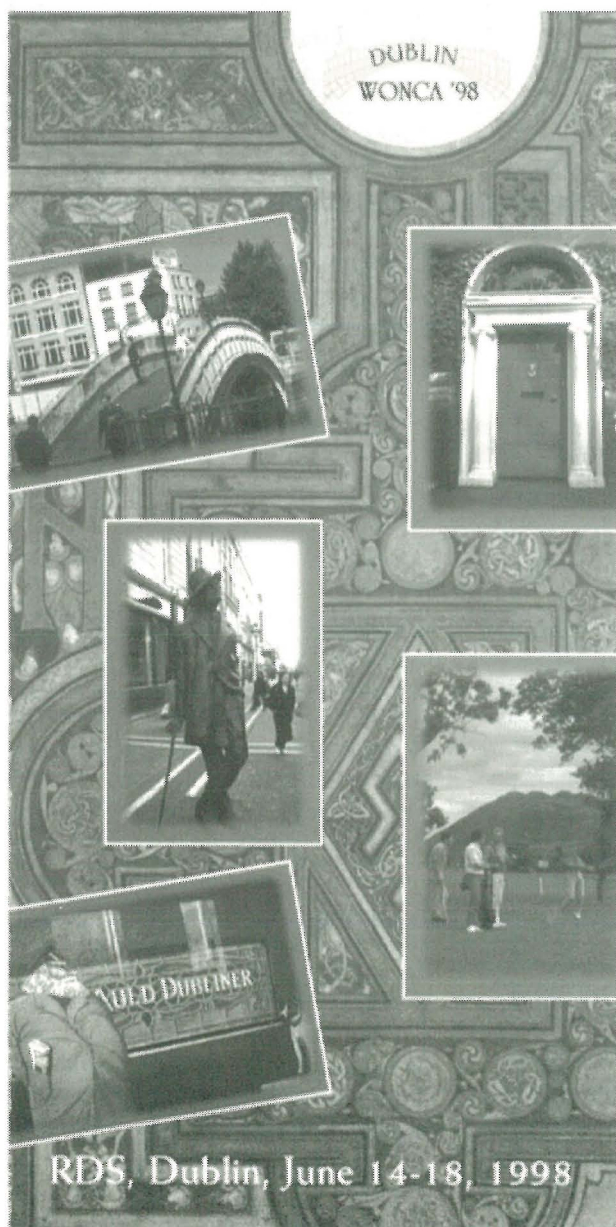
He thus went to the battle of Alma carrying only a small haversack and his small pocket



case of instruments⁹. The provision of the pocket-case of instruments became a strictly observed requirement in the Royal Navy by 1825. Each young doctor who joined his first ship had to supply himself with a small pocket-case of instruments not exceeding a cost of £5. This was to contain a scalpel, forceps, needles and sutures, to which later a hypodermic syringe was added. The abolition of the pocket-case was only approved by the Board of Admiralty in November 1933¹⁰.

REFERENCES

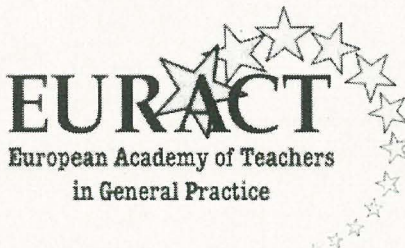
- 1 Cassar P. A naval medicine chest of the 17th century from Malta. *J Euro Pharmacy*. 2:36-43.
- 2 Cassar P. Professor Salvatore Luigi Pisani M.D. (1828-1908). *Malta Today*, 1982, 17(3):14-16.
- 3 Anon. *Surgical Instruments, Operation Tables, Sterilizers, Hospital Equipment*. London: Allen & Hanburys Ltd, 1957, p. 146-147.
- 4 Anon. *Aesculap – Hauptkatalog: General Catalogue*. Tuttlingen: Aesculap, 1991, p. 296-298.
- 5 Anon. *Down Surgical Instru-*
- ments: *Diagnostic, General, Intestinal*. London: Down Surgical Ltd, 1975, p. A23.
- 6 Anon. *Dimedra Surgical Instruments*. Tuttlingen: Dimedra, n.d., p. 105.
- 7 Anon. *Martin Chirurgie-Katalog*. Tuttlingen: Gebrüder Martin, 1978, p. 295-299.
- 8 Cassar P. *Medical History of Malta*. London: Wellcome Historical Medical Library, 1964, p. 531-532.
- 9 Laffery J. *Surgeons in the field*. London: Dent & Sons, 1970, p. 132.
- 10 Lloyd C, Coulter JLS. *Medicine and the Navy 1200-1900*. Livingstone: Edinburgh, 1968, vol. 4, p. 41, 273.




Slovenian medical association
Section for general practice


Medical Faculty Ljubljana


Institute of public health
of the Republic of Slovenia


EURACT
European Academy of Teachers
in General Practice

Network organisation within WONCA Region Europe - ESPG/FM

6th INTERNATIONAL WORKSHOP

LEARNING AND TEACHING ABOUT FAMILY IN GENERAL PRACTICE

Bled, Slovenija:
September 2-6, 1997

1. COUNCIL MEETINGS:

Eight meetings were held over the past year, with participation of members as follows:

D Soler	8	J K Soler	7	A P Azzopardi	5
M R Sammut	8	J P Gauci	6	W Galea	4
M A Borg	8	P Sciortino	6	R Busuttil	2
A Mifsud	7	J G Pace	5		

1. SUB-COMMITTEES & SECRETARIATS:

- **Subcommittee on Computerised Medical Records:** In May 1996, chairman Dr A P Azzopardi presented a recommended minimum data-set for computerised records, prepared with Dr W Galea and Dr H Agius Muscat. These recommendations were published on the College's Internet Homepage and in the College Journal.
- **Subcommittee on Specialist Training Programme:** Following the receipt of comments and suggestions from various international experts, especially Professor Douglas Johnson of Canada, the subcommittee worked hard over the past year to refine and further develop the draft programme. Amongst others, the Royal Society of Medicine, the European General Practice Research Workshop (EGPRW) and the International Committee of the Royal College of General Practitioners (RCGP) wrote to confirm their willingness to help in its implementation. The subcommittee has now started to prepare a workable version of this programme by gathering the required data and evidence needed to carry out a practical exercise of assessment of the local scene.
- **The Research Secretariat** is planning a *research course* over a long weekend, to be followed by a *Nivel Study* be carried out locally. A *Sentinel Service in General Practice* is to be coordinated with Dr Julian Mamo, Epidemiologist. A number of *local studies* are also to be carried out, including one on local medical record keeping.

1. CPD MEETINGS:

- On 3-6 October 1996, the **EGPRW Malta Meeting** took place under the auspices of the College at the Forum Hotel, St Andrew's. The theme of the meeting was Research in Social Problems in

General Practice, with over 100 participants from 25 countries. A good number of Maltese papers were read and were well-received in this "perfectly organised" meeting (ref. Dr Jan-Joost Rethans, EGPRW Treasurer). Dr Anthony Mifsud was confirmed as EGPRW's National Representative in Malta, and is to work in collaboration with Dr P Sciortino in the latter's capacity as College Research Secretary.

- On Saturday 12 October 1996, a one-day **Seminar on Palliative Care** at the Institute of Health Care was organised in conjunction with the Institute and the Hospice Movement.
- On 21 October 1996, a lecture entitled "**Nutrition of the Lactose Intolerant Infant**" was given by Dr Pierre Guesry, Vice-President of Nestle' Research, in co-organisation with Nestle'.
- On 23-25 October 1996, the **Autumn 1996 CPD Meeting – The ABC of Orthopaedics** – was held. This included the following presentations: *The Management of Neck and Back Problems* – Mr Charles J Gixti, *The Management of Hand Problems* – Mr Carmel J Sciberras, *The Management of Hip Problems* – Mr Anthony A Bernard, *The Management of Knee Problems* – Mr Frederick Zammit Maempel, *Interactive Session on Common Orthopaedic Problems* – Mr James N Casha and Mr Raymond R Gatt. Sponsors were Bayer AG & Roussel.
- On 15-16 November 1996, a **Joint Seminar on Paediatrics and Obstetrics & Gynaecology** was organised with the Malta College of Obstetricians & Gynaecologists and the paediatric Association of Malta at the Medical School. This was a success, both from the academic aspect and on a participative level.
- On 29-31 January 1997, the **Winter 1997 CPD Meeting – The ABC of Respiratory Medicine** – was held. The programme on the first evening was preceded by a short presentation from the Hon. Secretary of the ADD/ADHD Support Group (Malta), Mrs Tessa M Anastasi. The main presentations included: *Some Practical Aspects of Lung Function Tests in Paediatrics* – Dr Herbert M Lenicker; *Wake up to Obstructive Sleep Apnoea* – Dr Stephen Montefort; *The Challenge of Asthma – A Patient's Point of View* – Mrs Nathalie Ellul & Dr Joseph M Cacciottolo; *Environmental Factors in Respiratory Disease* –

Dr Martin J Ebejer; *The Price and Value of Asthma Care* – Dr Joseph M Cacciottolo; *Development of Glucocorticoid Therapy* – Prof. Roger Ellul Micallef. Sponsors were Glaxo Wellcome.

- On 14-16 February 1997, 13 College members participated in The European Association for the Study of Diabetes – **EASD Postgraduate Meeting on Diabetes Mellitus** which was held with great success at the Forum Hotel, St Andrew's.
- On 23-25 April 1997, the **Spring 1997 CPD Meeting – The ABC of Infectious Diseases** – was held. This included the following presentations: *Infectious rashes in childhood* – Dr S Attard Montalto, *Hepatitis – a clinical overview* – Dr A Caruana Galizia, *Emerging infectious diseases* – Dr C Mallia Azzopardi; *Fever in the Returned Traveller* – Dr M Muscat; *Immunisation – presentation and self-assessment* – Dr R Busuttil and Dr P Sciortino. Sponsors were Charles de Giorgio Ltd.
- On Thursday 8th May 1997, as part of the Skin Awareness Campaign organised by the Health Promotion Department, and in collaboration with the Department of Dermatology, Boffa Hospital, a CPD Lecture was given by Dr Michael J Boffa entitled **Skin Cancer – an Overview**.
- **Accreditation** was granted by the College to:
 - CME activities organised by the **Department of Primary Care**.
 - A Seminar on **Emergency Medicine – Practical Aspects** organised by SmithKline Beecham International with the St Luke's Emergency & Admitting Department on 24-26 January 1997.
 - **Postgraduate Lectures by the Dept. of Obs. & Gynae**, being held at Capua Palace/St Philip's every last Wednesday evening of the month from March 1997.
 - A scientific meeting on **Gene Therapy** held on Monday, 7th April 1997 by the Malta Chamber of Scientists. The internationally renowned speakers were Prof. Sir David Weatherall, Prof. Ryzard Kole and Prof. Steve Embury.
 - A lecture organised by the Coeliac Association of Malta on 29th April 1997 entitled **Coeliac Disease – the Tip of the Iceberg** by Mrs Rae Ward BSc (Nutrition) SRD, Consultant Dietician and Advisor to the UK Coeliac Society.

1. LOCAL NEWS:

- In May 1996, Dr W Galea was appointed webmaster of the College **Internet Website**.
- In July 1996, Dr Anthony P Azzopardi presented the College with his report of a joint meeting as College representative with the Faculty of Theology regarding '**The Allocation of Resources in the Health Care Sector**'.
- In September 1996, the Council accepted an offer by **TheSYNAPSE** – The Professional Intelligence Network – to host and maintain the College's Web Site and an on-line issue of *It-Tabib tal-Familja*.
- In 1996, College President Dr D Soler assisted in the set-up of the new **Good Shepherd Home in Mosta** for teenage girls, by coordinating medical and other ancillary services.
- As from 1st January 1997, **St Philip's Hospital** agreed to host the College. As such, the College resigned its associate membership of the Federation of Professional Bodies, however promising to maintain close cooperation with other professional bodies, members of the Federation.
- In January 1997, a courtesy call was paid to the Hon. Dr Michael Farrugia, MD, MP, the new **Minister of Health**.. He was presented with the following proposals for consideration: a three-month attachment for housemen and SHOs in general practice; the acknowledgement by government of CME undertaken by Health Centre Doctors; and support by government for family practice training, both vocational and specialist.
- In January 1997, the College accepted to endorse the medical content of a poster for the general public by SmithKline Beecham International on **chicken-pox and its impact**. This poster was published in April 1997.
- In early 1997, an **Information Booklet on Organ Donation** for Medical and Paramedical Professionals (in the preparation of which the College was involved) was distributed to College members.
- In February 1997 Dr Anthony Mifsud was appointed College **representative on a Department of Primary Care working group** studying access to physiotherapy services for private medical practitioners.
- In February 1997, a courtesy call was paid to Prof. E S Grech, present **Minister for Social**

Services and former Dean of the Medical School, during which the implementation of the Specialist Training Programme was discussed.

- In February 1997, at a request from the Director of Health Policy and Planning, Dr J K Soler was nominated as the College's **representative on a Standing Committee responsible for the Strategic Plan of Action on Asthma**.
- In April 1997, the College was asked to nominate family doctors as speakers in a Continuing Educational Update organised by the Malta Chamber of Pharmacists entitled '**The Maltese Pharmacist in Diabetes Care**' on 6-28 May 1997.
- On 1st May 1997, the College wrote to the Minister of Health regarding a paper he had received on the introduction of **Specialist Registration in Malta**, where Family Medicine was not included as one of the medical specialists. While the College acknowledged that at this time there are only few family doctors in Malta who have undergone specialist training, it insisted that, if Specialist Registration is introduced, Family Medicine be included as one of the specialities. The inclusion of Family Medicine in a Specialist Register thus would cater for present family medicine specialists, as well as those graduating from the College's Specialist Training Course to be set up in the near future.

1. INTERNATIONAL NEWS:

- On 9-12 May 1996, Dr A Mifsud and Dr J K Soler represented the College at the **EGPRW Vaxjo (Sweden) Meeting**, the last meeting before the Malta Meeting in October 1996.
- In June 1996, members of the College participated in a study **EGPRW Home Visits in European General Practice (Lisbon 1996)**, the report of which (**Report-Analysis of Pilot Study - Malta**) was presented to Council in March 1997.
- On 30 June - 4 July 1996, Dr D Soler, Dr W Galea & Dr M R Sammut represented the College at the **Stockholm WONCA 3rd European Congress on Family Medicine**, distributing copies of the College's proposed Specialist Training Programme for comments and endorsement by international peers.
- In September 1996, the **WONCA Working Party on Informatics** distributed web-site duties to its members, Dr J K Soler being made responsible for the maintenance of the page of the journal 'Family Medicine' and its links.
- In November 1996, College President Dr D Soler was an invited speaker at **The Mediterranean Medical Society Conference** held in Nicosia, Cyprus. His presentation was entitled *The Future of Family Medicine in Malta*. Dr Soler participated in discussions with Cyprus, Andorra and Greece to organise regional conferences for the Mediterranean countries that share many facets of medicine.
- In January 1997, the College Council decided to develop **contacts with WHO Region Europe**, especially regarding research and possible funding.
- In February 1997, College agreed to pay its **membership to WONCA Region Europe**, and through this to maintain its membership to WONCA World.
- In February 1997, the College accepted a request to be re-included in the latest version of the **American Academy of Family Physicians'** publication "Family, Physician and Student Opportunities in International Family Practice".
- In March 1997, the College accepted to cooperate with the newly founded **Italian Academy of Family Physicians**, at the request of its Chairman Dr Francesco Carelli. The Academy is to provide the College with details of its accreditation criteria and its requisites for qualification for membership.
- In March 1997, the College accepted a request by Dr Mario Falconi, FIMMG National Secretary, to take part in the **PRO.GM.AN.TEL, an EU initiative of ADAPT-FSE**.
- In April 1997, Research Secretary Dr P Sciortino was appointed **College representative to EGPRW**, and is to work in collaboration with the EGPRW's National Representative in Malta, Dr A Mifsud.
- On 8-11 May 1997 Dr A Mifsud and Dr J K Soler represented the College at the **EGPRW Meeting in London** on Research in Terminal Care, Continuing Care and Home Care for General Practice.
- On 30 June to 4 July 1997, Dr D Soler and Dr M R Sammut are to represent the College at the **1st Scientific Meeting of WONCA Region Europe - ESGP/FM** in Prague, Czech Republic, entitled **Prevention in Primary Care**. There, Dr Sammut will be giving a presentation entitled 'Smoking Habits and the Role of the Family Doctor'. The College has been honoured by invitations made to Dr Soler and Dr Sammut to chair sessions in this prestigious international meeting.

1. MEMBERSHIP & ACCREDITATION:

- 14 College members failed to pay their 1996 subscription fee by the end of October 1996 despite repeated reminders. As such, these were **deleted from the College's register** as per Council decision of 13/9/94.
- 1 member resigned due to inability to attend for meetings.
- As such, membership currently stands at 113 members.
- **56 college members were accredited for 1996**, 26 of which have maintained their accreditation status for the six consecutive years since 1991.

1. COLLEGE JOURNAL:

- The December 1995 issue was published in July 1996. **St Philip's Hospital** will be sponsoring the College Journal over 2 years.
- The July 1996 issue was issued in the beginning of 1997.
- The December 1996 issue was issued in June 1997.
- Council representatives are to meet with officials of **Lombard Bank** regarding the renewal of the bank's sponsorship of the College Journal.

1. COLLEGE NEWSLETTER:

- This is sent on a regular basis exclusively to College members, with local and international news of special interest to family doctors. In fact, while six issues were published in 1996, five newsletters already have been issued until May this year.

1. FUTURE PLANS:

- **Policy Document on Family Medicine in Malta:** The Council has felt the need for the preparation for such a document, in order to sensitise the public, the government and University to family medicine, raising the profile of the family

doctor as a specialist in his own right. The document has been sent to international experts with local experience for their comments. It is intended that the document be launched by a sustained and well-coordinated publicity campaign in the media.

- **CPD Meetings:** It has been proposed that these be reoriented to topics relevant to family practice.
- **Specialist Training Programme:** In April 1997, Council gave the subcommittee its commitment towards all that is needed to bring the programme to function, while keeping in mind the financial limitations of the College.

Call for Abstracts
Preliminary Programme

EQuIP
european working party on quality in family practice

Hosted by the Swiss
KOLLEGIUM FÜR HAUSARZTMEZIZIN
COLLEGE DE MÉDECINE DE PREMIER RECOURS
COLLEGIO DI MEDICINA DI BASE
and in collaboration with WONCA Region Europe
- the European Society of General Practitioners

**1st Open EQuIP
Conference**

**Quality
Improvement
in
Family
Practice
New Developments**

**6 - 8 November 1997
Zürich-Regensdorf, Switzerland**

swissair  official carrier

European Working Party on Quality in Family Practice



EUROPEAN GENERAL PRACTICE RESEARCH WORKSHOP LONDON 8-11 MAY 1997

ANTHONY MIFSUD

MALTA NATIONAL REPRESENTATIVE FOR EGPRW

RESEARCH IN TERMINAL CARE, CONTINUING CARE AND HOME CARE FOR GENERAL PRACTICE

8th May 1997

REPORT ON HOME-VISIT STUDY

A meeting between Antonio Jose Miranda and the National Co-ordinators for the pilot study about Home Visiting in Europe.

During this meeting, the results of the pilot study about home visits were discussed and answers sought for the various differences between the participating Countries.

* Malta has the **2nd highest home visit rate** – following Belgium.

During this meeting it was agreed that the pilot study has highlighted some logistic problems which will be rectified for the main study. Some of the variables studied will be left out for the main study (such as variables of the office consultation).

The Main Study about Home Visiting across Europe is feasible and will take place in the near future. During this year, an application for funding of the Main Study will be put forward to the European Union.

RECEPTION AT THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

In the evening the Delegates present were hosted by Lotty Newman the President of the Royal College of General Practitioners at their headquarters in London. This was an interesting evening, during which the history of the Building of the Royal College was explained in great detail. Dr Newman personally greeted and found time to chat with each delegate present.

THE WORKSHOP

Around 100 participants attended the two and half days workshop, during which:

- * 11 Theme Papers
- * 12 Free Standing Papers
- * 6 Five minute slide presentations

were presented and then, as is usual in such workshops were critically and constructively discussed by the participants present.

The workshop took place in a modern conference facility called the Atrium, at the Royal Free Hospital, Hampstead London.

SUMMARIES OF SOME INTERESTING PRESENTATIONS:

* **Palliative Home Care by Bart Van den Eyden (Belgium)**

This paper dealt with the practical logistic and financial aspects of caring for terminally ill patients at home by a multidisciplinary team, after such patients are discharged from hospital.

* **The burden of pain? by Maria E.T.C. Van den Muijsenbergh (The Netherlands)**

This qualitative research paper pointed out the fact, that although many doctors consider that pain and discomfort are the main problems that a family doctor has to deal with in terminally ill patients, such patients have a different opinion. Terminally ill patient are more concerned with the feeling of fatigue rather than pain.

* **Increasing the dose of morphine in terminally ill patients by Dick Willems (Amsterdam)**

An interesting observational study in which it is noted that many Dutch physicians have increased the dosage of morphine knowing that this might hasten the patient's death, but the increase in morphine dosage was remarkably low. Also most physicians thought that the last dose of morphine had hastened death, but still reported this as a natural death.

* **Wound management of 353 chronic ulcers by Rut Torner (Sweden)**

A qualitative research paper describing the decline in time taken for wound healing of leg ulcers over a ten year period when these are taken care of by motivated family physicians and nurses. The

author also described an innovative treatment of wound ulcers consisting of skin grafting using multiple small 2mm full thickness skin grafts taken from the same patient.

*** Tainted vision? General practitioners doing qualitative research.** By Frances Griffiths and Ruth Bridgewater (U.K.)

The authors used an innovative way to present their paper which compared and contrasted qualitative vs quantitative research in general practice. The two authors presented the pros and cons of qualitative and quantitative research by presenting the audience with a theatrical performance which was greatly appreciated.

MEETING BETWEEN EGPRW EXECUTIVE BOARD AND THE NATIONAL REPRESENTATIVES

- Since the Malta EGPRW meeting, workshops are becoming more popular (>100 participants) and this has happened again in London and will probably happen again in the future. This is a positive sign in that it means that the popularity of EGPRW is increasing. But this creates logistic and organisational problems in that with increasing numbers, active discussion during the workshop may be hindered and organising EGPRW meetings is becoming more complex. This brings us to several questions. Do we need to limit the number of participants? How should we do this? Do we need to change the way EGPRW are organised. A discussion followed aiming to solve some of the above questions.
- **Scoring of Abstracts:** For this workshop, a number of good abstracts had to be declined from participation. A discussion followed re the criteria to be used for scoring abstracts.
- **Future EGPRW meetings:** The next workshop is going to be held in Barcelona Spain between the 16th and 19th of October 1977. The central theme will be 'Early Diagnosis of carcinoma in Primary Care'.
- **Elections EGPRW:** In Barcelona elections for the EGPRW chairman will take place. Profs. P. Wallace will not contest a 2nd term of office.

- **EGPRW Home page on the Internet:** It was agreed that the EGPRW will have its own web page. This will be organised by the Maltese delegation namely Dr J K Soler and will be hosted for free on the Synapse. The home page will contain besides other features, the abstracts presented during the workshops.

FUTURE DEVELOPMENTS

- We were approached by the delegates from Andorra and we have agreed to form an association for the Small Countries of Europe interested in upholding academic and research activities in Primary Care. This will tentatively be called SEC GP (the Small European Countries General Practice Group).

During the preliminary discussions which took place between delegates from Andorra, Malta and Estonia, it was pointed out that Small Countries of Europe have similar characteristics as regards Primary Care, and it would be useful if we collaborated closer together in various projects.

It was agreed that we will draft out a statute for this organisation which will be circulated to Andorra and Estonia. This will be presented in the future, and other Small European Countries will be invited to join.

MSc COURSE IN PRIMARY CARE RESEARCH

Dr. Frank Dobbs from Plymouth is developing an MSc Course in Primary Care Research, to be delivered by distance learning methods. In the future an MSc course in Primary Care will also be developed. The MSc course is open for foreign participants and may be of interest to some of our members.

Frank Dobbs was very interested in the MCFD project for specialist training in Malta, and will be very happy to review and comment on the final draft document.

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INTRODUCTION

Childhood diabetes (IDDM) is generally accepted to concentrate on insulin-dependent diabetes first occurring in subjects younger than 15 years of age, but it must be remarked that this type of diabetes can and indeed does appear in older patients, both adolescents and adults. In the latter this often seems to be a late-onset, slow developing form of insulin-needing diabetes which could at times be mistaken for secondary failure to oral hypoglycaemic agents. This condition was greatly underestimated in Malta for a long time, having been overshadowed by the much more common form of diabetes – NIDDM, whose prevalence here has been reported to be the highest in Europe. However, recent findings clearly show that this type of diabetes is not at all rare in our population; in fact its incidence ranks among the higher in the Mediterranean area.

PATHOPHYSIOLOGY

A brief overview of the pathophysiology of this condition reveals that IDDM is basically an auto-immune disorder appearing in the genetically predisposed and precipitated by unknown factors/s (environmental, ? viruses, etc). This causes an insulinitis which in the presence of other triggering factors leads to the destruction of the beta pancreatic cells and eventually to an insulin-deficiency, ketosisprone state. It is also known that although the clinical onset is rather abrupt occurring within days or weeks, the pathological process is much longer having developed slowly over months or years. After a variable period from diagnosis the condition then often passes through a remission (honeymoon) period where the needs of insulin become minimal for a while, before finally proceeding to total and permanent insulin dependence.

DIAGNOSIS AND MANAGEMENT

The diagnosis of this condition is unequivocal most of the times – the typical history, and characteristic symptoms and signs making it clear to

reach. This consists in an acute onset, in subjects below 20 years and desirable weight, of polyuria, polydipsia, weight loss, fatigue and weakness accompanied by heavy glycosuria, frequent ketonuria and marked hyperglycaemia. Specialized testing (although rarely needed for diagnostic purposes) show evidence of reduced C-peptide levels in the fasting state and in response to stimulation.

The management of IDDM is built around intensive insulin therapy, good hydration, meal planning (balancing nutrients with exercise and insulin) as well as education and psychological support for both patient and relatives. Monitoring of child development, blood glucose, glycated Hb, and other parameters as indicated, and the screening for complications and/or concomitant diseases are also essential during the regular follow-ups.

EPIDEMIOLOGY

The prevalence of this disease in the mid 80s in Maltese children younger than 15 years was 81/100,000, being higher in girls than in boys (94 vs 69). The mean

incidence per 100,000 during the period 1980-96 was of 14 (girls 15, boys 13), translating in an average number of 11 new cases per year. These are generally made up of 2 cases in the 0-4 age group, 4 cases in the 5-9 age group and 5 cases in the 10-14 age group. There seem to have been no statistically significant fluctuations over this period (with the exception of 1993 when 21 new cases were detected); yet the yearly incidence appears to have possibly increased slightly in the last few years from a mean of 10.8 in the period 1980-89 to an average of 12.7 during the interval 1990-96. The last few years also suggest a possible trend towards an earlier onset of the disease and an evening of the male/female ratio.

COMPARATIVE INCIDENCE RATES

The incidence rates of IDDM in Malta result to be just about higher than those of most other countries along the Mediterranean littoral, with the exception of Sardinia which has been reported to have a level approaching that of Nordic countries where IDDM is the highest in the world. However

unlike many of the Southern European countries this condition does not appear to be more prevalent in boys than in girls.

CHARACTERISTICS

Like elsewhere, the onset of IDDM in the Maltese shows a seasonal variation with the majority of cases being diagnosed in the cooler months of the year (November to February), and the lowest during the warmer summer months. Intriguingly a similar pattern was observed in the months of birth of the subjects. Boys tended to develop IDDM circa 2 years later than girls (14 vs 12 years). The commonest age group in which the disease appeared is 10-14 years, followed by the 5-9 for females and 20-24 for males.

In the Maltese the mean interval between the onset of symptoms and the start of insulin increased with increasing age at onset of the disease, varying between averages of 1 week in the 0-4 year olds and 3 weeks in the 10-14 year olds. The inverse was noted to occur with the mean amount of insulin per kg body weight needed for control – this dropped from a mean of 0.9 units in the 0-4 year olds to a mean of 0.6 units in the 10-14 year olds.

INFLUENCING FACTORS

The prevalence of IDDM in Malta was found to be influenced by a number of factors which include a 3rd or later birth rank, a maternal age at birth of the subject of more than 35 years, and lack or less than 3 months of breast feeding. Interestingly the latter habit not only seemed to protect against IDDM but also appeared to delay the onset of the disease.

The role of viral infections in IDDM in Malta is unclear, these were reported in circa 20% of cases, preceding the onset of the disease by an average of 6 weeks. Genetics also seem to be of potential relevance but more detailed study is clearly needed.

HEREDITY

The aspect of heredity was investigated from the presence or otherwise of a positive family history of diabetes in close relatives of the IDDM subjects. As expected IDDM was commoner in parents of IDDM children than in those of non diabetic offspring (4.0% vs 0.5%). Interestingly the same was noted for NIDDM, this form of diabetes being also more frequent in parents of IDDM children than in those of non diabetic ones (13.5% vs 4.5%). This could suggest that NIDDM might be associated with childhood diabetes.

IDDM was commoner in sibs of affected children than in those of non diabetic ones, the mean prevalence in the former being 8.6% (brothers 8.4%, sisters 8.8%). IDDM girls had more affected sibs than IDDM boys (11% vs 6%). Again it was noted that the risk of IDDM was enhanced by parental NIDDM too – the prevalence of IDDM in sibs of IDDM was higher if the parents had NIDDM than if they were not diabetic (16% vs 10%).

COMPLICATIONS

The complications of this form of diabetes are both of acute and chronic nature. An outline of these shows that the former include uncontrolled hyper-glycaemia which could lead to a serious condition called diabetic ketoacidosis, and hypogly-caemia resulting from improperly balanced

treatment. The chronic complications consist of both the disease specific microvascular ones involving the eyes, kidneys and nerves and the non specific macrovascular ones. Their presence and severity are influenced by the sex and age of the subject, the age at onset of IDDM, and possibly also by genetic factors, but mainly by the duration of the disease and the degree of glycaemic control. IDDM patients eventually also develop atherosclerotic cardio-vascular disease which, like microangiopathy, is associated with risk factors (including smoking, hyperlipidaemia, hypertension etc).

Unfortunately reliable figures of the rates of complications in Maltese IDDM patients are still not available, but should not be very different from elsewhere. It has been noted that circa 5-10% of IDDM cases already have some evidence of incipient complications after 10 years of diabetes, the prevalence of pathology increasing dramatically thereafter, reaching mean level of 20-30% by 15 years of IDDM and 60-80% after 20 years of disease. An European study reported that after 18 years of IDDM levels of microvascular complications averaged 31% renal, 46% ophthalmic and 19% neuropathic. It also found a mean of 12% cardiovascular disease, 15% hypertension, and 6% peripheral angiopathy.

Blood glucose control also plays an important role in the prevalence of disease. Data from Malta showed that in cases of severe retinopathy half the patients had had poor control and only 18% were deemed to have had acceptable glycaemic levels.

The complications and concomitants of diabetes lead to a significantly higher risk of death. This increased mortality in IDDM compared to non diabetic subjects is mainly due to renal, hypertensive and ischaemic heart disease.

CONTROL

As already stated, glycaemic control influences the occurrence of complications. Good control can not only prevent or delay complications but has recently been shown to be able to regress them too if strict and persistent enough. To achieve this requires dedicated team work and close monitoring. Tight control however also carries a significant risk of hypoglycaemia and hence particular attention is needed in its management. The maintenance of satisfactory control and avoidance of complications necessitates the removal of risk factors (like smoking, infection, etc.) and appropriate therapy of any co-existing pathology (including auto-immune related conditions, thyroid disorders, coeliac disease, asthma, high blood pressure, nephropathy, dyslipidaemia, etc.).

On the other hand it must be recalled that the commoner causes of poor control include, amongst others, insufficient compliance, lack of education and/or motivation, conditions of 'stress', unrecognized occurrence of the rebound (Somogi) or dawn phenomena and others (eg. insulin resistance states). Also associated with the degree of glycaemic stabilization is the utilization of health services by IDDM patients. Detailed information on this in Malta is not at hand but it is estimated that the proportion of subjects that regularly keep on attending the diabetes clinics drop from

an initial 90% to circa 60% after 5 years and to some 30% by 10 years. Moreover also the frequency of visits decreases in time; indications suggest that of those patients that keep coming for follow-up after a number of years of IDDM only about 27% attend for the scheduled 5 to 6 visits per year, 33% make 3 to 4 visits a year, whilst circa 40% merely come once to twice yearly.

THE FUTURE

The future for IDDM patients augurs well. Intensive research is being conducted towards various aspects of the disease. In particular studies are being done to improve treatment by

developing new insulin analogues and forms (eg. spray), and providing better monitoring and more sensitive screening tests. Great efforts are being made to try to cure the disease by islet cell transplantation and/or possibly prevent it. The latter involves intervening on the susceptible who are now becoming possible to identify by means of special markers (including humoral auto-antibodies against islet cell, insulin, GAD, IA2 and phogrin). Newer approaches in this field have moved from immuno-suppression towards immuno-modulation by means of BCG vaccination, low dose insulin, exclusion of cow's milk from early nutrition, etc.

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SUMMARY

Objective: To establish trends in preoperative diagnostic cardiac catheterisation in congenital heart disease (CHD)

Design: Retrospective analysis of performance of catheterisation preoperatively for 1st, 2nd, 3rd and 4th operation for significant and complex CHD.

Setting: Regional hospital providing CHD diagnostic and follow-up services for all Malta.

Patients: Patients operated for CHD between 1947 and 1994.

Main outcome measures: Whether or not preoperative catheterisation was performed.

Results: 651 operations were carried out for CHD between 1947-1994. The proportion of patients undergoing cardiac catheterisation prior to surgery has declined ($p=0.0004$). Further analysis showed that this trend was due to a reduction in the proportion of patients undergoing catheterisation prior to 1st operation for significant CHD ($p<0.0001$). This group constituted 75% of all operations. No trends were found in other types of operations.

Conclusions: Echocardiography, a non-invasive technique, has supplanted cardiac catheterisation as the primary diagnostic tool prior to 1st operation for significant CHD. However, catheterisation maintains a role for investigation prior to other operations for CHD.

INTRODUCTION

Congenital heart disease (CHD) is the commonest congenital malformation. The term is a label for a heterogeneous group of lesions with varying haemodynamic consequences and hence, varying need for follow-up and intervention/s. Diagnosis, follow-up and treatment of CHD is expensive. Population based studies are important aids for the planning of future likely requirements since allocation of finite resources is a ubiquitous public health problem.

Malta is a small, central Mediterranean country with a total population of around 370,000 and a birth rate of around 5300 deliveries per annum¹. This provides a relatively closed population furnishing an ideal setting for epidemiological and historical studies regarding CHD.

METHODS

Definitions

CHD was defined as a structural abnormality of the heart or intrathoracic great vessels that is actually or potentially of functional significance². The following conditions were excluded:

1. Arrhythmias, unless accompanying structural abnormalities.
2. Persistent patency of the arterial duct occurring in association with prematurity and which resolved spontaneously or required treatment before 3 months of age.
3. Bicuspid aortic valve in the absence of aortic valve stenosis.
4. Isolated mitral valve prolapse with or without mitral incompetence.

5. Isolated dextrocardia in the absence of accompanying structural abnormalities.

6. Atrial septal defects that closed spontaneously on follow-up or were shown echocardiographically to be haemodynamically insignificant and therefore would not require intervention.

7. Dilated and hypertrophic cardiomyopathies.

Confirmation and Hierarchy

Cases with multiple CHD diagnoses had their lesions classified hierarchically. The primary lesion was considered that lesion which first required intervention. In cases where no intervention was necessary, the primary lesion was considered that which produced the most haemodynamic disturbance.

CHD was graded by severity to allow broad classification into three groups. Complex CHD included all conditions with valve or chamber atresia or hypoplasia such as hypoplastic left heart syndrome and tricuspid and pulmonary atresia.

Severe CHD included conditions where all cardiac structures were present but surgery or interventional cardiac catheterisation was necessary, or was anticipated to be necessary in future e.g. Ventricular and atrial septal defects, tetralogy of Fallot and transposition of the great arteries.

Mild CHD included all lesions in which no intervention had been done and in which none is planned in future.

Patients and Population

All Maltese patients who have undergone surgery for CHD were included in this study. Recent studies dealing with the epidemiology of CHD have only included patients diagnosed by 1 year of age. Due to the historical nature of this study, this condition was not applied.

Operations were classified into those with pre-operative cardiac catheterisation and those without pre-operative cardiac catheterisation. Cardiac catheterisation was divided into 2 types: diagnostic and interventional. Catheters included in this study were pure diagnostic procedures, and interventional catheters in which balloon septostomy was performed. Catheterisation prior to operation was defined in the following way:

For 1st operation – Catheter performed any time prior to operation.

For 2nd operation – Catheter performed after 1st and before 2nd operation.

For 3rd operation – Catheter performed after 2nd and before 3rd operation.

For 4th operation – Catheter performed after 3rd and before 4th operation.

Data sources

Sources included children being followed up at Children's Outpatients for CHD with or without other problems, copies of all paediatric echocardiogram reports, lists of locally performed elective cardiac catheters and operations and lists of patients sent abroad for urgent cardiac catheterisation or intervention not available in Malta. In addition, clinic registers of patients seen at visiting consultant paediatric cardiologist clinics which are held 3-4 times a year were examined.

Database and statistics

Patients with CHD were entered onto a dedicated database (Maltese Paediatric Cardiology Database). Diagnoses and interventions were coded with a Version 2 Read Codes Browser. A series of programs were used to extract data which was analysed with Excel and Epi-Info. Analysis of trends was performed using the χ^2 test for linear trends. A p value of 0.05 was taken to represent a statistically significant result.

RESULTS

A total of 651 operations were carried out in the period 1947-1994 inclusive. There was a significant trend towards an increase in the ratio of catheterised: uncatheterised patients from 0.5 in 1960-64 to 1.1 in 1990-94 (χ^2 12.21 - 0=0.0004).

Significant CHD

A total of 579 operative events were carried out for significant CHD over the period 1947-1994. These were subdivided into 1st, 2nd, 3rd and 4th operations for CHD. 491 operations were 1st operations while 88 were 2nd, 3rd and 4th operations (table 1). 1st operations for significant CHD constituted 75% of all operations for CHD.

The numbers of uncatheterised and catheterised operations for 1st operation for significant CHD are shown in figure 1. The ratio of uncatheterised: catheterised operations increased significantly from 0.2 in 1960-64 to 1.4 in 1990-94 (χ^2 21.03 - $p < 0.0001$). Uncatheterised cases were comprised almost exclusively of patent ductus arteriosus and coarctation of the aorta prior to the mid-1980s. Other lesions began to be operated without prior catheterisation after the mid-1980s.

The 5-year totals of uncatheterised and catheterised operations for 2nd, 3rd and 4th operation for significant CHD are displayed summated in figure 2. The ratio of uncatheterised: catheterised operations failed to display any trends (χ^2 1.91 - $p = 0.16$).

Complex CHD

A total of 72 operations were carried out for complex CHD, which included 1st, 2nd, 3rd and 4th operations. Due to the small numbers, the 5-year totals of uncatheterised and catheterised operations for all operations for complex CHD were summated and are shown in figure 3. The ratio of uncatheterised: catheterised operations remained unchanged from 0.5 in 1960-64 to 0.5 in 1990-94 (χ^2 2.36 - $p = 0.12$).

Table 1: Surgery for Maltese patients with CHD (1947-1994)

Operations	Significant CHD	% of total	Complex CHD	% of total
1st	491	75%	34	5%
2nd	76	12%	22	3%
3rd	11	2%	15	2%
4th	1	0%	1	0%
	579	89%	72	11%
	Grand total		651	

Figure 1: Catheterisation prior to 1st operation for Significant CHD

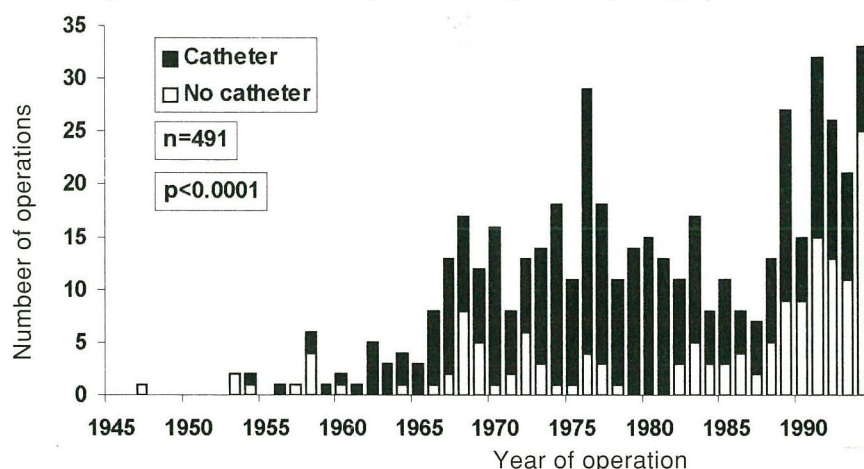


Figure 2: Catheterisation prior to 2nd, 3rd & 4th operation for Significant CHD

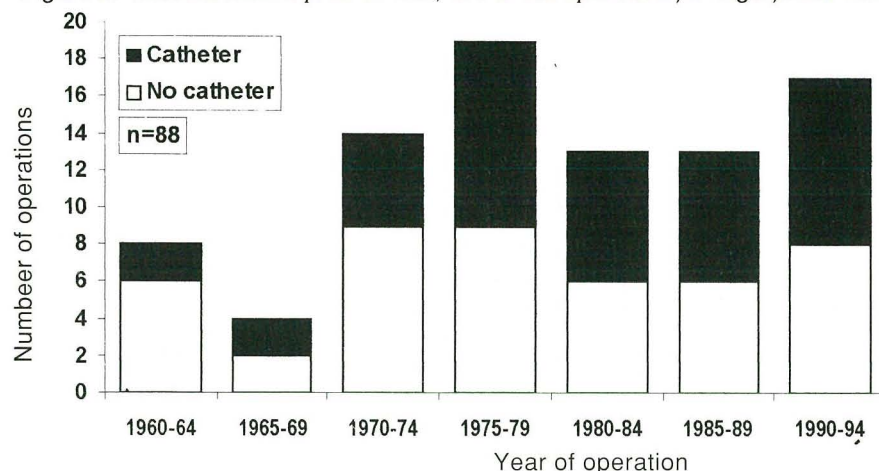
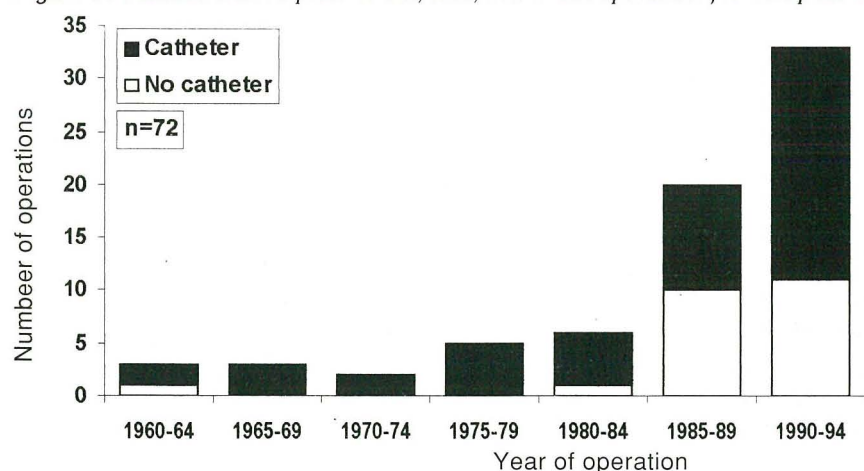


Figure 3: Catheterisation prior to 1st, 2nd, 3rd & 4th operation for Complex CHD



DISCUSSION

Malta has strong medical links with the UK which date back to the 1st World War. Although the Maltese Medical School is the second oldest in the world, there are insufficient doctors in training to allow the establishment of local postgraduate examination boards. It has been the custom for the majority of postgraduate trainees to undergo further training and examination in the UK, which has further strengthened the medical links between the two countries. This has led to visiting cardiologists over the past 30 years all being based in England³. Hence, the developments in local paediatric cardiology services have run in parallel with services in the UK. The small size of the country enabled all patients diagnosed as having CHD to be identified and entered onto a database by a single person, ensuring complete ascertainment and accuracy of all diagnosed cases. Since diagnostic and interventional decisions were undertaken by the above-mentioned consultants, it is reasonable to assume that the trends found locally can be extrapolated to larger countries.

Significant CHD

Cardiac catheterisation was formerly the only reliable diagnostic test available to the paediatric cardiologist. However, it is an invasive procedure and is not without some risk of morbidity and mortality⁴. This was particularly the case prior to the development of isotonic contrast medium. For this reason, catheterisation was frequently omitted in cases where a diagnosis could be established clinically due to clear physical signs as in coarctation of the aorta and patent ductus arteriosus. Definitive diagnosis would then be established at surgery. The introduction of

echocardiography in the mid-1980s allowed diagnosis to be established non-invasively, and the addition of Doppler measurements and colour-Doppler flow-mapping further augmented the value of this investigation by increasing the information that could be obtained during the procedure. This led to a gradual decline in the need for pre-operative catheterisation for significant CHD which began in the mid-1980s⁵. However, catheterisation is still used for the performance of balloon septostomy in transposition of the great arteries with inadequate intracardiac mixing, and to delineate the coronary arteries as in tetralogy of Fallot where complete repair in the region of the right ventricular outflow tract may damage an aberrant coronary artery.

Further operations for significant CHD frequently need catheterisation as these may be done to redo the original operation which may have been partly or wholly unsuccessful. In these situations, it is natural to attempt to gather all of the information possible by any means available prior to reoperation.

Complex CHD

Although echocardiography is often sufficient for surgery to be undertaken, some details may not be sufficiently clear. This is particularly the case when details of intrapulmonary vasculature are required such as in pulmonary atresia, as ultrasound cannot penetrate air.

CONCLUSION

Echocardiography, a non-invasive diagnostic technique, has supplanted cardiac catheterisation as the sole mode of investigation prior to surgery for the majority of cases of CHD. Cardiac catheterisation remains useful for investigation prior to operations in excess of the first for significant CHD, and for all operations for complex CHD. The role of cardiac catheterisation in these areas has been reduced by transoesophageal echocardiography⁶, and may be further decreased by developments of non-invasive techniques such as 3-dimensional echocardiography⁷.

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REFERENCES

1. Central Office of Statistics. Demographic review for the Maltese Islands for the years 1990-1994. Central Office of Statistics 1994, Malta, pp 10-11.
2. Mitchell SC, Korones SB, Berendes HW. Congenital heart disease in 56109 births. Incidence and natural history. *Circulation* 1971; 43:323-332.
3. Galea-Curmi M. The Hospitalisation of the Maltese Patient Abroad. University of Malta (Thesis) 1984, Malta, p28.
4. Fyler DC, Buckley CP, Hellebrand WE, Cohn HE. Report on the New England Regional Infant Cardiac Program. *Pediatrics* 1980; 65:376-461.
5. Marek J, Skovranek J, Hucin B, Chaloupecky V, Tax P, Reich O, Samanek M. Seven year experience of noninvasive pre-operative diagnostics in children with congenital heart defects: comprehensive analysis of 2,788 consecutive patients. *Cardiology* 1995;86:488-495.
6. O'Leary PW, Hagler DJ, Seward JB, Tajik AJ, Schaff HV, Puga FJ, Danielson GK (1995). Biplane intraoperative transesophageal echocardiography in congenital heart disease. *Mayo Clin Proc*; 70:317-326.
7. Vogel S, Ho SY, Lincoln C, Yacoub MH, Anderson RH. Three-dimensional echocardiography can simulate intraoperative visualization of congenitally malformed hearts. *Ann Thorac Surg* 1995; 60:1282-1288.

INTRODUCTION

Snoring, up till only a few years ago treated by the medical community as a social inconvenience, is now showing convincing evidence of actually being a health hazard.

Many researchers now rate the public health hazards of snoring on the same scale as smoking.

Studies show that approximately 25% of men, 18% of women and 11% of children snore and these figures rise with increasing age and obesity. The severity of snoring may vary from occasional loud breathing sounds to life-threatening obstruction of the airway called sleep apnoea. Sleep apnoea affects about 3% of middle aged men and 2% of middle aged women.

HOW DO PEOPLE SNORE?

Snoring sounds usually arise from the floppy back part of the roof of the mouth. The roof of the mouth, or palate, consists of a front hard bony portion, and a back flexible muscular portion ending in an elongate structure called the uvula.

As the individual breathes in during sleep, the relaxed throat muscles collapse and the uvula vibrates as a result of turbulent airflow. Wind instruments such as the clarinet and oboe work on much the same principle.

HOW CAN SNORING BECOME DANGEROUS?

When airway collapse at the back of the throat is severe, airflow ceases and oxygen levels in the bloodstream drop to critical levels. Such periods of breath holding are known as Apnoeic Spells and they recur throughout the night producing a condition known as Sleep Apnoea. Patients often stop breathing until an inbuilt alarm in the brain goes off, partially arousing the individual from sleep. As a result, the sleep pattern is disturbed, giving rise to excessive daytime sleepiness. Lack of oxygen is associated with heartbeat irregularities, high blood pressure and strokes.

CLINICAL SIGNS AND SYMPTOMS

Patients are known to drop off to sleep at the wheel of their car causing traffic accidents. As a result of daytime somnolence, work performance suffers. Other clinical features include impaired concentration, memory disturbances, aggression and impotence. Snoring is a cause of marital disharmony and has been quoted as a cause of divorce in countries such as the UK. Children may fall asleep in class, have learning difficulties, morning headaches or failure to thrive. Nightmares, bed wetting and restlessness during sleep are also associated symptoms.

People more prone to snoring have physical attributes such as obesity, a short neck, blocked nose, large tonsils or adenoids. The latter is the most common finding in children. Drinking alcohol in the evening increases muscle relaxation during sleep and makes snoring worse.

MANAGEMENT

Weight loss is extremely important as with increasing obesity fat infiltrates the throat muscles decreasing their tone and making them more prone to collapse. No alcohol should be taken before retiring at night. Examination by an ENT surgeon should be carried out to exclude simple problems such as a bent nasal septum, nasal polyps, enlarged tonsils or adenoids or a particularly long and thick uvula. A procedure known as Nasoendoscopy is often carried out. Under local anaesthetic administered by spray a narrow, flexible fiberoptic telescope looks at the nose and upper air passages so as to visualise the site of maximal collapse.

Patients whose history is suggestive of sleep apnoea are selected for a 'sleep study'. The individual in this case has an oxygen-sensing probe fitted to his/her finger and monitoring is carried out during a night's sleep. Sleep apnoea sufferers are offered a special machine that blows air through a mask, and they have to wear this mask during sleep for the rest of their lives. As a result, long term compliance is not very good.

Most snorers do not have sleep apnoea and their snoring may be improved or abolished by means of appropriate surgery depending on the site of obstruction. Surgery may be required to remove nasal polyps, correct a bent nasal septum or remove large tonsils or adenoids. Laser may be used to remove the vibrating uvula and a small segment of adjacent soft palate. This is called LAUP or Laser Assisted UvuloPalatoplasty. The carbon dioxide laser has proved itself in the United States, France,

the United Kingdom, and is now available in Malta. Its main advantage over conventional surgical instruments is that while it cuts, it seals off blood vessels and its application results in less bleeding,

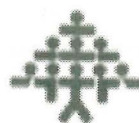
less tissue swelling and less long term scarring. LAIP is carried out on a day case basis, and the patient is advised that he/she would have a sore throat for a week.

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CONTINUING PROFESSIONAL DEVELOPMENT 1997 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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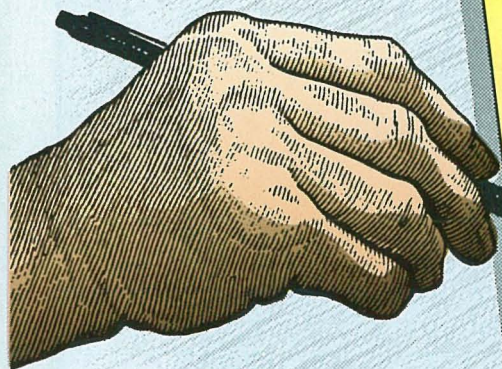
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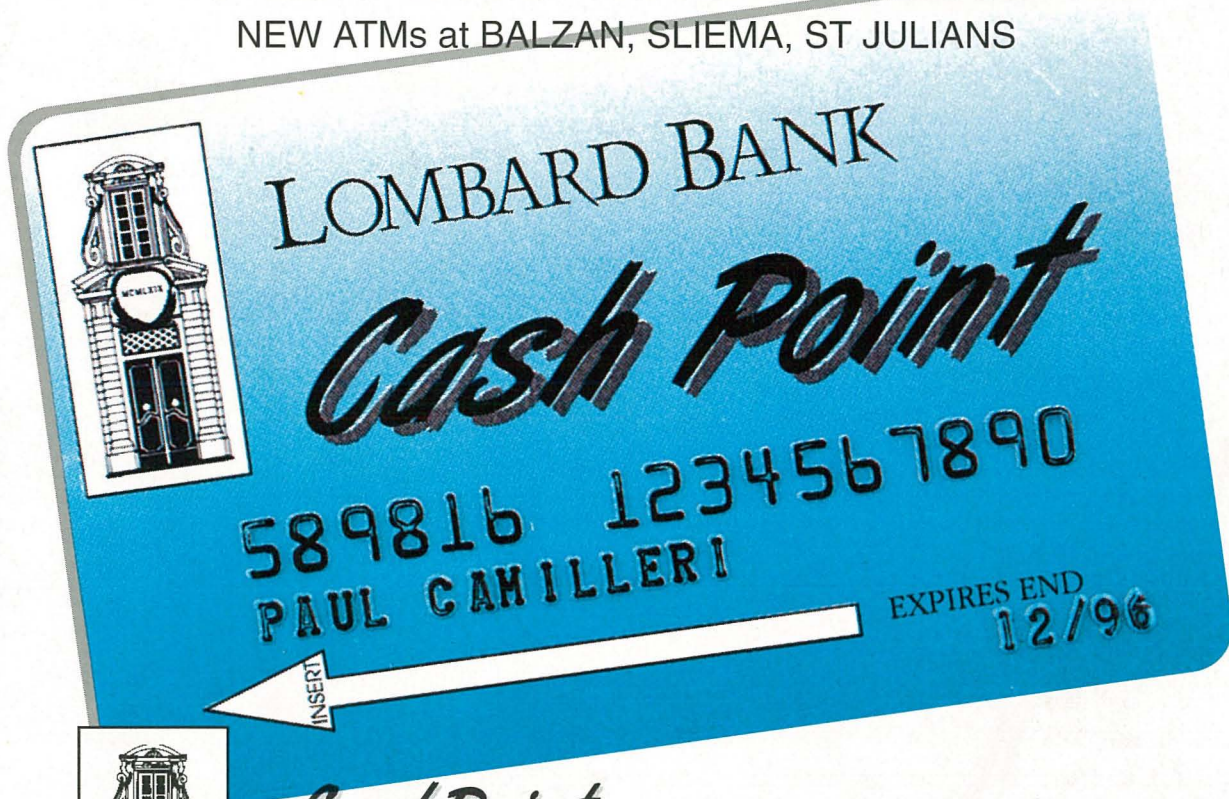
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