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Dear Readers,

This is my last editor's letter, as I am now retiring from my post as main editor, whilst retaining a secondary position on the editorial board. I hope that this move will create a vacuum, and thus act as an incentive for a new editor, and new editorial style, to take over and bring the wind of change and rejuvenation to this journal. This is the main motivation for my choice to change my role.

I look back, now, to my first days as editor in 1993. The journal was then an upgraded black and white newsletter sent to College members. My first decision, as fledgling editor, was to upgrade it to a full-colour journal published twice a year and sent to all doctors on the Islands free of charge. The choice was expensive and risky, but it quickly paid off with more returns from advertising due to the improved circulation numbers. The journal has moved from strength to strength over the years, and has now developed into a Mediterranean journal of Family Medicine, regularly accepting work from Italy, Turkey, Slovenia, and other neighbouring countries. Our illustrious advisory and peer review boards have acted as important partners in this move to better quality.

The next development in quality will be the drive to index this journal in the Index Medicus. This will require more regular publication; a drive to attract more and more submitted papers to allow us to be more selective in our publications, and another upgrade in terms of redimensioning the advertising strategy to require less adverts and move more conference announcements to our newsletter.

I wish the new Editorial Board every success in achieving these ambitious goals. However, as I did in 1993, I am sure the new editor will rise to the occasion!

Jean Karl Soler
Editor
1. Council and its meetings:

Seven meetings were held since the last AGM of 16/4/2002. Council members’ attendance was as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A P Azzopardi</td>
<td>7</td>
</tr>
<tr>
<td>A Micallef</td>
<td>7</td>
</tr>
<tr>
<td>J G Pace</td>
<td>7</td>
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<tr>
<td>M R Sammut</td>
<td>7</td>
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<tr>
<td>J K Soler</td>
<td>7</td>
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<tr>
<td>D Soler</td>
<td>6</td>
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<tr>
<td>M A Borg</td>
<td>6</td>
</tr>
<tr>
<td>W Galea</td>
<td>5</td>
</tr>
<tr>
<td>P Sciortino</td>
<td>5</td>
</tr>
<tr>
<td>A Mifsud</td>
<td>4</td>
</tr>
<tr>
<td>P Mallia</td>
<td>2</td>
</tr>
<tr>
<td>(till October 2002)</td>
<td></td>
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<tr>
<td>F P Calleja</td>
<td>2</td>
</tr>
<tr>
<td>(from November 2002)</td>
<td></td>
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</tbody>
</table>

Following Council elections, Council posts were assigned as follows during the Council Meeting following the AGM on 16/4/02:

- Dr Denis Soler
  President
- Dr Joseph G Pace
  Vice President
- Dr Mario R Sammut
  Honorary Secretary
- Dr Anthony Mifsud
  Honorary Treasurer
- Dr Michael A Borg
  College Registrar
- Dr Wilfred Galea
  Secretary for International Affairs
- Dr Anthony P Azzopardi
  Secretary for Quality Assurance
- Dr Jean Karl Soler
  Secretary for Research and Publications
- Dr Philip Sciortino
  Secretary for Education
- Dr Pierre Mallia
  Secretary for Ethics
- Dr Adrian Micallef
  Assistant Honorary Secretary and Secretary for Communications.

Council agreed that each secretary (namely International Affairs, Quality Assurance, Research & Publications, Education, Ethics, Communications) was to prepare a strategic report outlining proposals for the next 3 years, and identify key people as members of his team. However, the only reports presented and approved were those for the International Secretariat and for the College Journal (in May 2002 – see below).

In October 2002, Dr Pierre Mallia resigned as Council member due to other increasing commitments, while staying on as member of the College’s Ethics and Education sub-committees. In November 2002, Dr Frank P Calleja was informed him that, in accordance with Section 6.6 of the College Statute, he was automatically elected as a member of the College Council. In December 2002, Council welcomed him back into its ranks and offered him the post of Secretary for Ethics (instead of Dr Mallia), which Dr Calleja accepted.

2. Presentation of three-year strategic plans:

- In May 2002, Council approved the International Secretariat’s Strategy presented by Dr W Galea, which focusing on the following two issues:
  - Obtaining international endorsement for MCFD Membership by Examination;
  - Disseminating information to members re implications of proposed Malta membership to the EU, specifically through a meeting organised/funded with the help of MIC.

- Also in May 2002, Dr J K Soler presented a Strategy for the College Journal. The main problems were highlighted as follows:
  - The possibility of making a loss through a lack of adverts. Council agreed that each Council member tries to find a new advertiser.
  - Poor web presence. Council agreed that past and future Journal articles be put on the College website.

3. MCFO-RCGP Teachers’ Course, Vocational Training Scheme, MMCFO by Examination:

- As had been announced by College President Dr D Soler during the last AGM held on 16/4/02, a Teachers’ Course was organised locally by the College in collaboration with the University Department of Family Medicine, not only for Departmental lecturers, but also for any others who were interested in view of a future need for tutors in family practice. In fact, the three modules of this course were held on the 24-26 May and 20-22 September 2002 (both at the Forum Hotel, St Andrew’s) and on the 1-4 May 2003 (at the Coastline Hotel, Salina). The coordinator was Dr Philip Sciortino, while the RCGP tutors were Dr John Howard (for the first module only), Dr Marek Jezierski, and Prof. Rosslynne Freeman (for the second and third modules). The participants were
Dr Anthony P Azzopardi, Dr Michael A Borg, Dr Frank P Calleja, Dr Doreen Cassar, Dr Wilfred Galea (in the first and second modules), Dr Pierre Mallia, Dr Anthony Mifsud, Dr Joseph G Pace, Dr Mario R Sammut, Dr Denis Soler (in the first and second modules), Dr Jean Karl Soler and Dr Vincent Zammit. The remit of the subcommittee was as follows:

• In May 2002, a Teachers’ Course Subcommittee was formed to draw up recommendations on the way forward. The members were Dr Philip Sciortino as Chairman, Dr Pierre Mallia, Dr Frank Calleja, Dr Doreen Cassar and Dr Vincent Zammit. The remit of the subcommittee was as follows:

  o Short-term: initial recommendations, including the organisation of a follow-up meeting.
  o Medium-term: follow up MCFD Membership by Assessment/Examination scheme and prepare a working document (in collaboration with Hon. Treasurer Dr A Mifsud regarding costing);

• In March 2003, Dr D Soler revealed that the call for applications for a coordinator and trainers for the proposed Vocational Training Scheme was awaiting the Prime Minister’s endorsement, which will not be forthcoming before the April 2003 general elections. Regarding the MMCFD by Examination, Dr D Soler noted that other countries around the world are negotiating with the RCGP for certain concessions to allow local trainee GPs to do the highly-reputable MRCGP. The College Council agreed to a proposal by Dr Soler that this be the way forward for Malta instead of the College reinventing the wheel by developing an expensive local course and examination. The MCFD would have a role through the Teachers’ Group in preparing local candidates for the exam.

4. Family Medicine as aspeciality in the Health Care Professions Act:

• In October 2002, it was agreed by Council that the College stand on the matter was:
  o The College sets the criteria for registration/specialisation as a family doctor;
  o Vocational training in family medicine is required for practise both with the government and privately;
  o No doctors can be registered in more than one speciality;
  o The College has full membership in the Specialist Accreditation Committee.

• On the 26th November 2002, two meetings were held by representatives of the College Council (Dr D Soler, Dr J K Soler, Dr P Sciortino, Dr A Micalelfe and Dr M R Sammut - the latter for the second meeting only) with Dr L Deguara, Minister of Health, and Dr R Busuttil, Director General (Health) respectively. As a result of these meetings, it was confirmed that Family Medicine would be listed under such name in the list of specialties in the HCPA.

• In December 2002, Council recommended that Dr M R Sammut write as College Honorary Secretary to the General Secretary of the Medical Association of Malta to declare the College’s position regarding the HCPA, namely: (1) that Family Medicine be put at par with other specialties in the list of specialties; (2) family doctors on the specialist list be nominated by the Specialist Accreditation Committee (SAC) on the recommendation of the College; (3) doctors on the Medical Register and not on the specialist list can practise as medical doctors but without the appellation of ‘Family Doctor’. The Medical Association of Malta replied on 27th January 2003 agreeing with all three points.

5. CPD Activities:

• The Spring CPD Meeting was held on the 24-26 April 2002 at the University of Malta Medical School and entitled ‘Family Medicine Revisited’. Charles De Giorgio Ltd. accepted to be sponsors of the meeting, with the programme as follows:

  o Wednesday 24th: ‘Primary Care in Malta: Provision, Problems and Proposals for Reform’ – Dr Mario R Sammut, Family Doctor; ‘The Cumulative Patient Profile: a Useful Tool in Patient and Practice Management’ – Dr Wilfred Galea & Dr Fred Demanuele, Family Doctors.
  o Friday 26th: ‘The Domain of Family Practice in an International Perspective: Empirical data collected with ICPC’ – Dr Inge M Okkes, Department of Family Practice, University of Amsterdam; ‘Malta is no longer an Island in Family Practice: First Experiences with Transhis as an Electronic Patient Record’ – Prof. Henk Lamberts, Department of Family Practice, University of Amsterdam.

• Prof. H Lamberts and Dr I Okkes visited Malta for 2 weeks during April-May 2002 and organised 2 workshops for Transhis users, participated in the Spring CPD meeting (as described above), and gave a presentation to members of the College Council as well as of the Department of Family Medicine.

• The Autumn CPD Meeting 2002 took place on 2-4 October 2002 at the Medical School, and was sponsored by Schering-Plough. The meeting was entitled ‘Manifestations of Atopy: an
Accelerating Epidemic of Interrelated Conditions', and had the following programme:

- **Wednesday 2nd**: **ASTHMA**: Dr Michael A Borg, Family Doctor, Concepts and Cases; Dr Stephen Montefort, Respiratory Physician, New Evidence & Developments; Dr Mario R Sammut, Family Doctor, Skills & Practice Management.
- **Thursday 3rd**: **ALLERGIC RHINITIS**: Dr Doreen Cassar, Family Doctor, Concepts and Cases; Dr Mario Said, ENT Surgeon, New Evidence & Developments; Dr Frank P Calleja, Family Doctor, Skills & Practice Management.
- **Friday 4th**: **ATOPIC ECZEMA**: Dr Jean Karl Soler, Family Doctor, Concepts and Cases; Dr Mario Said, ENT Surgeon, New Evidence & Developments; Dr Anthony Mifsud, Family Doctor, Skills & Practice Management.
- **Wednesday 11th**: **The Family Doctor as a Specialist**: Dr Jean Karl Soler, Dr Pierre Mallia, Dr Denis Soler. (Chairman: Dr. Philip Scioritino).

**The Winter CPD Meeting** was held on 12-14 February 2003, at the Medical School, G'Mangia. It was entitled "The Future of Family Medicine in Malta and the Role of the Malta College of Family Doctors", and the sponsor of the meeting was Delta Ltd. The programme was as follows:

- **Wednesday 12th**: The Doctors' Directives: ED regulations on the medical profession - Dr Adrian Micallef, MCFD; The Speciality of Family Medicine in Europe - Dr Tonio Xuereb, MAM; Specialist Training in the European Union - Dr Stephen Fava, MAM.
- **Thursday 13th**: The academic role of the Malta College of Family Doctors - Dr Philip Scioritino, MCFD; College research and publications: past, present and future - Dr Jean Karl Soler, MCFD.
- **Friday 14th**: Family Medicine and the draft Health Care Professions Act - Dr Ray Busuttil, Director General (Health).

A series of lectures on Paediatrics is being organised this year with the Maltese Paediatric Association. These consist of 3 evening lectures, each a joint presentation by a family doctor and a paediatrician. Dr P Scioritino is coordinating on behalf of the College, with sponsorship provided by Astra-Zeneca. The first took place on 2nd May 2003 at the Corinthia Palace Hotel, Attard, and was entitled 'Paediatric Emergencies - An Interactive Exercise'. The joint speakers were Dr S Attard Montalto and Dr M R Sammut.

The College also approved requests for accreditation of the following activities under its CPD Scheme:

- GSK's 'Take Care 3' Lectures on Psychiatry held during April-May 2002;
- Dr Robert Xuereb's symposium on Cardiac Rehabilitation held on 10th May 2002.
- A seminar on "Doctors and Disabled Persons – Towards a Better Understanding" organised by the Health Division on 28th February 2003.

6. Local news:

- In May 2002, Dr Joseph Dimech from the Department of the Elderly gave a presentation to the College Council regarding the introduction of specialised team geriatric services in the government homes for the elderly (starting with Mtarfa Home) and the role of the family doctor in this team.
- In May 2002 the Council nominated Dr A P Azzopardi as its representative on the Specialist Accreditation Committee, which post Dr Azzopardi accepted.
- On 29th August 2002, Dr M R Sammut and Dr A Micallef represented the College in a seminar entitled 'Introducing a National Drug Policy in Malta' organised by the Medicines Policy and Audit Unit of the Health Division.
- In October 2002, the Council nominated College member Dr Tanya Mellilo Fenech as the College's representative to the Breast Care Support Group committee.
- In October 2002, the College Council nominated Dr Pierre Mallia to prepare feedback on the College's behalf on a draft code of ethics entitled "Sharing the News" prepared by National Commission Persons with Disability.
• In October 2002, Dr A Mifsud confirmed that he was attending on a regular basis meetings of the Health Division’s National Antibiotics Committee in his capacity of College representative, and updated Council on recently discussed topics.

• In November 2002, Council agreed that the College assist in the identification of at least 10 family doctors (through the MCFD Newsletter) to participate in an Influenza sentinel surveillance system that is to be set up by the Department of Public Health.

• In December 2002, Council agreed that a Report on Influenza Vaccination in Childhood commissioned the Maltese Paediatric Association, be circulated to College members in the MCFD Newsletter.

• In December 2002, following the termination of the previous hosting arrangement with Capua Palace Hospital, the College Council agreed that the MCFD enters into an agreement for the use of premises of the Malta Federation of Professional Associations as from 1st January 2003 at the rate of Lm 200 a year, with expenses (water and electricity) to be shared pro-rata and the hall to be used against extra payment.

• In December 2002, Council agreed that snippets on the EU Directives regarding family medicine be sent electronically to College members. Dr W Galea with Dr A Micallef coordinated such mailings.

• In December 2002, the Director General Health appointed the President of the College (or a representative) to the ‘National Adolescent Health Coalition’. Dr A Micallef accepted to be the College’s representative.

• In February 2003, the Director General Health appointed the President of the College (or a representative) to a working group to draw up a ‘National Health Strategy for Communicable Disease Prevention’. Dr M R Sammut volunteered to be the College’s representative.

• In March 2003, Council accepted a proposal by Dr Pierre Mallia to organise on behalf of the College, and in collaboration with the National Commission Persons with Disability and the Bioethics Committee, a yearly course for doctors on giving bad news to patients, on condition that participants are selected after a call open to all College members.

7. International news:

• Dr D Soler and Dr M R Sammut represented College at the WONCA Europe 2002 ESGP/FM Conference ‘Promoting excellence in family medicine’ held in London on 9-13 June 2002. Dr D Soler participated in a Council Meeting of WONCA Europe at the same conference. Dr M R Sammut presented two personal papers, one joint paper, participated in a workshop and chaired a session. Both Dr Soler and Dr Sammut self-financed their participation through the help of sponsors.

• In June 2002, a background paper entitled ‘Developing a Mediterranean family medicine group’, of which Dr J K Soler was the first author, was published in the European Journal of General Practice of June 2002. Among other activities, the group will coordinate papers from Mediterranean family doctors for publication in the College Journal ‘The Family Physician – It-Tabib tal-Familja’.

• In August 2002, Dr J K Soler announced that the WONCA International Classification Committee will be holding a meeting in Malta on 5-9 October 2003, and wished to coordinate a meeting with the College on the 8th October 2003 regarding the state of academic family medicine and the use of ICPC in Malta. Council agreed that the meeting with the College be coordinated by Dr J K Soler.

• In September 2002, Dr A W T Loh, CEO of WONCA, wrote to the College (in its role as a WONCA Council member) to request its participation in a Survey being undertaken by the WONCA Task-Force on Tobacco Cessation. Dr M R Sammut completed the survey on behalf of the College, as a result of which it appeared that the College had done very little in the area of smoking cessation. As such, in October 2002, Council accepted Dr Sammut’s proposal that the College invite the coordinators of an Irish College of General Practitioners one-day workshop on ‘Brief Intervention Training on Smoking Cessation in General Practice’ to hold such workshop in Malta, with the workshop funded by a sponsorship from the local representatives of a drug company.

• On the 19th November 2002, Dr D Soler represented the College at an RCGP International Development Meeting held at the premises of the Royal College of General Practitioners in London. As a result of such meeting, Dr John V Howard, Chairman of the RCGP International Committee, on the 2nd December 2002 wrote to Dr Soler as College President, where he confirmed that the RCGP would provide tutors for the 3rd module of the Teachers’ Course due in Spring 2003, and suggested a booster 3-day module in 2004 (against a fee). The RCGP also offered its academic support for the Vocational Training Scheme and for the MMCFD by Examination, both also against a fee.
In March 2003, Dr D Soler announced that, in reply to Dr John Howard’s letter of the 2nd December 2002 (where he requested that a Memorandum of Understanding regarding RCGP support for academic initiatives be signed jointly by the two Colleges), Dr Howard had been informed that, due to the then uncertainty regarding Malta’s membership of the EU, such decision would need to wait until after the national elections due to be held in Malta during April 2003.

8. Membership and Accreditation:

- In November 2002, seven members were deleted from the College register as per Council decision of the 13/9/94, for not having paid their membership fee for 2002 despite repeated reminders.

- Membership at present stands at 153.

- Thirty-four College members were accredited for 2002, 12 of which have maintained their accreditation status for the twelve consecutive years since 1991.

9. College Journal and Newsletter:

- In April 2002, Dr Frank P Calleja was nominated to form part of the Journal’s Editorial Board and subsequently accepted.

- The December 2001 and June 2002 editions of the College Journal were distributed in October 2002.

- The December 2001 issue of ‘The Family Physician’ included the following articles on family practice: ‘An Audit of Discharge Summaries’, by Vinker, Nakar, Zibulevski, Gorodeski, Schattner & Kitai (from Israel); ‘Professional Independence in General Practice’ by Svab (Slovenia); ‘Perceptions of Residents’ Working Conditions in Family Medicine: A Cross-sectional Survey in Turkish Academic Training Hospitals’ by Yaman (Turkey).

- The June 2002 issue included the following family-practice related report: ‘The Opinion of Family Physicians on their Working Conditions in the Turkish Health Care System’ by Ugur (Turkey).

- The MCFD Newsletter continues to be sent on a regular basis exclusively to College members, with local and international news of special interest to family doctors.

15th May, 2003
SCIENTIFIC PROGRAMM

Up till now, our search concerning the themes of the Scientific Program has delivered the following:

Overall Theme:

"From Hippocrates to the Human Genome:
The past, present and future of General Practice/Family Medicine"

Themes of the Conference:

• Measuring Effectiveness in GP/FM
• Randomised Control Trials in Primary Care
• Chronic Illness Management in GP/FM
• Assessing Patient and Family Opinion in Gp/FM
• Cultural Determinants of Illness and the Role of GP/FM
• Needs Assessment in GP/FM
• Community Oriented Primary Care as a Tool for Serving Better the Catchment Area
"European Network for Prevention and Health Promotion in Family Medicine and General Practice"

Network organization within WONCA Region Europe-ESGP/FM

EUROPREV SECRETARIAT

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Faster and sustained freedom from GERD symptoms in more patients than omeprazole.4,5
Clinically proven to heal more reflux esophagitis patients in a shorter period of time compared to omeprazole.4,5
The first PPI developed as an isomer

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PHARMACODYNAMIC PROPERTIES: Nexium® reduces gastric acid secretion through a highly targeted mechanism of action by being a specific inhibitor of the acid pump in the parietal cell.

INDICATIONS AND DOSAGE: Treatment of erosive reflux esophagitis: Nexium® 40 mg once daily for 4–8 weeks. Long-term management of patients with healed erosive esophagitis to prevent relapse: Nexium® 20 mg once daily. Symptomatic treatment of gastro-esophageal reflux disease: Nexium® 20 mg once daily in patients without esophagitis. Once symptoms have resolved, an on demand regimen of 20 mg once daily can be used when needed, to control subsequent symptoms.

Helicobacter pylori-associated peptic ulcer disease: Healing of H pylori-associated duodenal ulcer, prevention of relapse of peptic ulcers in patients with H pylori-associated ulcers: Nexium® 20 mg, amoxicillin 1 g and clarithromycin 500 mg, all bid for 1 week. CONTRAINDICATIONS: Known hypersensitivity to esomeprazole, substituted benzimidazoles or any other constituents of the formulation. PRECAUTIONS: In the presence of any alarm symptoms (eg significant unintentional weight loss, recurrent vomiting, dysphagia, haematemesis or melena) and when gastric ulcer is suspected or present, the possibility of gastric malignancy should be excluded before treatment is initiated. Patients on long-term treatment should be kept under regular surveillance. The risk of drug interaction should be considered especially when prescribing esomeprazole in combination with antibiotics for eradication of H pylori or as on demand therapy. USE IN PREGNANCY AND LACTATION: Caution should be exercised when prescribing Nexium® to pregnant women. Nexium® should not be used during breast-feeding.

INTERACTIONS: Due to the decreased intragastric acidity, the absorption of ketoconazole and itraconazole can decrease during esomeprazole treatment. When Nexium® is combined with diazepam, citalopram, imipramine, clomipramine and phenytoin the plasma concentrations of these drugs may be increased and a dose reduction could be needed. Concomitant administration of esomeprazole resulted in a 45% decrease in clearance of diazepam. Concomitant administration of esomeprazole resulted in a 15% increase in trough plasma levels of phenytoin in epileptic patients. The plasma concentrations of phenytoin should be monitored when treatment with esomeprazole is introduced or withdrawn. In healthy volunteers, combined therapy with esomeprazole and cisapride resulted in a 32% increase in AUC and a 31% prolongation of elimination half-life but no significant increase in peak plasma levels of cisapride. ADVERSE REACTIONS: The following adverse drug reactions have been identified or suspected in the clinical trials programme. None was found to be dose-related. Common: nausea/vomiting, diarrhoea, constipation, abdominal pain, flatulence and headache. In rare cases the following were reported or suspected: dermatitis, pruritus, urticaria, dizziness and dry mouth. PRESENTATIONS: Nexium® tablets containing esomeprazole magnesium corresponding to 20 mg or 40 mg esomeprazole. Date of preparation: July 2000. Since indications, dosage forms and strengths may vary from country to country, please consult your local prescribing information. For further information please contact AstraZeneca, S-431 83 Mölndal, Sweden, or the local AstraZeneca subsidiary.

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Zinnat is indicated for infections of upper and lower respiratory tract, skin and soft tissue.

**Presentations**
White tablets containing 125 mg, 250 mg and 500 mg cefuroxime axetil, suspension containing 125 mg cefuroxime axetil per 5 ml.

**Dosage**
- **Adults:** Most infections - 250 mg twice daily. Lower respiratory tract infection - 250 mg twice daily. Pneumonia - 500 mg twice daily. Urinary tract infection - 125 mg twice daily. Pyelonephritis - 250 mg twice daily. Uncomplicated gonorrhoea - 1 g single dose.
- **Children:** Most infections - 125 mg twice daily. Otitis media - 3 months to 2 years 125 mg twice daily, 2 years to 12 years 250 mg twice daily. Tablets should not be chewed or crushed and therefore are not suitable for children under five years of age. Zinnat should be taken after food for optimum absorption.

**Contra-indications**
Hypersensitivity to cephalosporin antibiotics.

**Precautions**
Zinnat may, in general, be given to patients who are hypersensitive to penicillins, although cross-reactions have been reported with some cephalosporins and special care indicated in patients who have experienced anaphylactic reaction to penicillin. Cefuroxime axetil should be administered with caution during early months of pregnancy.

**Side effects**
Gastrointestinal disturbances including diarrhoea, nausea and vomiting had been reported, these are generally mild and transient in nature. As with all broad spectrum antibiotics, there have been rare reports of pseudomembranous colitis. Rarely, hypersensitivity reactions, eosinophilia and transient increase of hepatic enzyme levels have been noted.

**Package quantities**
All strengths of tablets are supplied in foil strips in packs of 10. Suspension is supplied in bottles containing 50 ml and 100 ml.

**Abbreviated Prescribing Information**
- **Uses**
  - Zinnat is indicated for infections of upper and lower respiratory tract, skin and soft tissue.
- **Presentations**
  - White tablets containing 125 mg, 250 mg and 500 mg cefuroxime axetil, suspension containing 125 mg cefuroxime axetil per 5 ml.
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- **Package quantities**
  - All strengths of tablets are supplied in foil strips in packs of 10. Suspension is supplied in bottles containing 50 ml and 100 ml.

**References:**
2. ZINNAT Approved Product Information.
ABSTRACT

Aim: There are many antibiotics used in acute sinusitis in paediatric practice. We planned this study to contribute rational antibacterial treatment considering the clinical efficiency, side effects and cost of the treatment.

Materials and methods: Our study was a prospective, randomized and open label study in children. Patients diagnosed as having acute sinusitis based on the major and minor clinical diagnostic criteria were randomized to receive 14 days of amoxicillin (40 mg/kg/day, in 3 doses), 5 days of azithromycin (10 mg/kg/day, single dose for first 3 days and 5 mg/kg/day-single dose for 2 days) and 14 days of cefprozil (30 mg/kg/day, 2 doses).

Results: Of a total of 151 patients who were between the ages of 5 and 14 years (mean: 8.33±2.82 standard error), 50 patients received amoxicillin, 52 azithromycin and 49 cefprozil. At the end of the treatment improvement rates were 72 %, 80.7 %, and 69.3 % respectively (p>0.05). The occurrence rates of adverse effects were 8 %, 7 %, and 10 % in these groups respectively (p > 0.05).

Conclusion: We emphasize that clinicians should prefer appropriate antibiotics for acute sinusitis in children, in regard to the parameters of low cost, high compliance and minimum adverse effects.

Key words: amoxicillin, azithromycin, cefprozil, children, sinusitis, treatment

INTRODUCTION

Acute sinusitis is a common disease that millions of people suffer from in the world. In United States of America 3 million people are diagnosed with sinusitis in a year. This is the fifth leading cause of outpatient infectious disease. Inaccurate or misdiagnosis of sinusitis leads to many problems in the course of the disease. Resolution of symptoms is delayed, and insufficient antibiotic use may cause chronic sinusitis. In some conditions serious bacterial complications may occur. On the other hand, antibiotic abuse may increase the treatment cost, side effects, and bacterial resistance. So it is important to determine the cost-effective treatment strategies (1).

In the literature we could not find a comparative study of amoxicillin, azitromycin and cefprozil in childhood sinusitis. When the diagnosis is accurate in childhood sinusitis antibiotic treatment is needed. Kakish et al conducted a study in 249 acute sinusitis patients. They gave antibiotics to 88% of them and did not give any antibiotics to 12% of them. Amoxicillin was the drug of choice in 35.8% of those given antibiotics; 23% azithromycine, 15% cefaclor, 10% TMP-SMX, 8.5% amoxicillin-clavulanic acid, 3.5% ampicillin, 3.5% clarithromycin were the others. At the end of the study on the 10th day they controlled the patients and found a significant difference between the treated and untreated group. The treatment group improved (3). According to the clinical literature data, in acute sinusitis judicious antibiotic treatment is needed in order to prevent the development of complications and chronicity (1).

Nasal cytology does not give any information about the intrasinusoidal bacteriology (4). Anterior...
rhinoscopy needs exact patient compliance and for children this is very difficult. Antral puncture is accepted as the gold standard in literature but it takes long time, is invasive and painful.

Antibiotic prescription for acute sinusitis in outpatient practice, can have a major impact on cure and costs. We performed a prospective open label study to compare effectiveness of the three antibiotics in the treatment and cost of acute sinusitis in childhood.

MATERIALS AND METHODS

Our study was a prospective, randomized and open label study in children. Patients diagnosed as having acute sinusitis based on the major and minor clinical diagnostic criteria were randomized to receive 14 days of amoxicillin (40 mg/kg/day, in 3 doses), 5 days of azithromycin (10 mg/kg/day, single dose for first 3 days and 5 mg/kg/day- single dose for 2 days) and 14 days of cefprozil (30 mg/kg/day, 2 doses).

All the patients included in the study were evaluated by the same doctor (DB). Children having any other disease were not included in the study. History of drug hypersensitivity and/or allergy, any antibiotic use fifteen days before the admission, malignancy, serious heart, liver, kidney or gastrointestinal disease were also criteria for non-inclusion.

Diagnosis of acute sinusitis was made by history and clinical findings. In Table-1, the major and minor criteria used for the diagnosis of acute sinusitis were given (4). According to these, patients having at least two major, or one major and two minor criteria were accepted as acute sinusitis (2). (Tables 2, 3).

Treatment effectiveness of the three antibiotics were evaluated according to the improvement in clinical findings and complaints. (Tables 4, 5).

Table-2 Distribution of the study groups according to complaints at admission*

<table>
<thead>
<tr>
<th></th>
<th>I. Group (Amoxicillin)</th>
<th>II. Group (Azithromycin)</th>
<th>III. Group (Cefprozil)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n:50)</td>
<td>(n:52)</td>
<td>(n:49)</td>
</tr>
<tr>
<td>Fever</td>
<td>41(82)</td>
<td>52(100)</td>
<td>49(100)</td>
</tr>
<tr>
<td>Cough</td>
<td>26(52)</td>
<td>44(84.6)</td>
<td>36(73.5)</td>
</tr>
<tr>
<td>Headache</td>
<td>39(78)</td>
<td>26(50)</td>
<td>36(73.5)</td>
</tr>
<tr>
<td>Nasal discharge</td>
<td>27(54)</td>
<td>30(57.7)</td>
<td>28(57.4)</td>
</tr>
<tr>
<td>Congestion</td>
<td>22(44)</td>
<td>15(28.8)</td>
<td>13(26.5)</td>
</tr>
<tr>
<td>Halitosis</td>
<td>10(20)</td>
<td>3(5.8)</td>
<td>10(20.4)</td>
</tr>
</tbody>
</table>

*ppercentages are to be evaluated for the same group

In our study the most common complaints were fever, cough and headache (Table 2).

Table-3 Distribution of the study groups according to physical examination findings at admission *

<table>
<thead>
<tr>
<th></th>
<th>I. Group (Amoxicillin)</th>
<th>II. Group (Azithromycin)</th>
<th>III. Group (Cefprozil)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n:50)</td>
<td>(n:52)</td>
<td>(n:49)</td>
</tr>
<tr>
<td>Postnasal drainage</td>
<td>50(100)</td>
<td>52(100)</td>
<td>49(100)</td>
</tr>
<tr>
<td>Fever</td>
<td>39(78)</td>
<td>52(100)</td>
<td>49(100)</td>
</tr>
<tr>
<td>Nasal discharge</td>
<td>27(54)</td>
<td>16(30.8)</td>
<td>25(51)</td>
</tr>
<tr>
<td>Halitosis</td>
<td>11(22)</td>
<td>4(7.7)</td>
<td>7(14.3)</td>
</tr>
</tbody>
</table>

*ppercentages are to be evaluated for the same group

The most common physical examination findings at the admission were postnasal drainage and fever. (Table 3).

Table-4 Distribution of the study groups according to complaints and physical examination findings at control *

<table>
<thead>
<tr>
<th></th>
<th>I. Group (Amoxicillin)</th>
<th>II. Group (Azithromycin)</th>
<th>III. Group (Cefprozil)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n:50)</td>
<td>(n:52)</td>
<td>(n:49)</td>
</tr>
<tr>
<td>Fever</td>
<td>%0</td>
<td>%2</td>
<td>%6</td>
</tr>
<tr>
<td>Cough</td>
<td>%43</td>
<td>%20</td>
<td>%34</td>
</tr>
<tr>
<td>Headache</td>
<td>%25</td>
<td>%42</td>
<td>%26</td>
</tr>
<tr>
<td>Nasal discharge</td>
<td>%37</td>
<td>%52</td>
<td>%47</td>
</tr>
<tr>
<td>Nasal congestion</td>
<td>%46</td>
<td>%42</td>
<td>%59</td>
</tr>
<tr>
<td>Halitosis</td>
<td>%18</td>
<td>%0</td>
<td>%0</td>
</tr>
<tr>
<td>Postnasal drainage</td>
<td>%36</td>
<td>%31</td>
<td>%41</td>
</tr>
</tbody>
</table>

*ppercentages are to be evaluated for the same group

When we compare the complaints and physical examination finding before and after treatment, there were no statistically significant differences between the groups (p>0.05). The most persistent finding was nasal congestion in all three groups.

1) "Cure" was defined by disappearance of the two major, or one major and two minor criteria
2) "Partial clinical improvement" was defined by disappearance of one major criteria and/or any minor criteria.
3) "Failure" was defined by persistence of one major criterion. The failure group was sent to the Outpatient Unit of the Ear-Nose-Throat section. Patients were asked for the adverse effects in the control examination. (Table 5).

The statistical analysis of this study was done by SPSS 10.0, p values less than 0.05 were accepted as significant.

In the evaluation of the parameters, Student's T test, Chi square and Correlation test was used. The data was given as mean and standard deviation.

**RESULTS**

A total of 151 patients who were between the ages of 5 and 14 years were included in the study (mean: 8.33±2.82 standard error). In our study 50 of 151 patients received amoxicillin, 52 azithromycin and 49 cefprozil. At the end of the treatment improvement rates were 72 %, 80.7 %, and 69.3 % respectively (p>0.05). (Table 6). The occurrence rates of adverse effects were 8 %, 7 %, and 10 % in these groups respectively (p> 0.05). (Table 5).

**DISCUSSION**

Acute sinusitis is a very common infection in childhood, but its management remains a controversial issue. Cefprozil and azithromycin are acceptable alternatives to amoxicillin in the treatment of sinusitis in children. As stated before, because of the risk of complications and chronicity this study was not designed as placebo controlled. History and physical examination was used for diagnosis. Waters' radiological view and leukocyte count was important for supporting the clinical diagnosis. Ros et al. compared the Waters’ view with three dimensional head views and found that Waters’ view is sufficient with a sensitivity of 89% and a specificity of 83% in diagnosing acute sinusitis (5). So we used the Waters’ view not as a diagnostic tool it to but to evaluate the relationship with the clinical diagnosis.

Engels et al made a meta-analysis in which 6 studies for the diagnosis of acute sinusitis were included. In one part of the meta analysis sinus aspiration ad sinus radiographs were compared. When the positivity of X-rays was defined as the presence of fluid in the sinus and/or opacity and/or mucosal thickening they found out the sensitivity as0.9 and specificity as 0.61 (1). Stewart et al states that in primary care, the physician does not need imaging techniques for diagnosing uncomplicated acute sinusitis (7). In our study there were correlation between Waters’ view improvement and general clinical outcome. We have the results which are parallel with the studies suggesting that every imaging technique needs to be evaluated under the light of history and clinical examination (1, 4, and 5).

### Table-5 Distribution of the study groups according to adverse effects

<table>
<thead>
<tr>
<th></th>
<th>I. Group</th>
<th>II. Group</th>
<th>III. Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n:50)</td>
<td>(n:52)</td>
<td>(n:49)</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nausea</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Constipation</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>%8</td>
<td>%7</td>
<td>%10</td>
</tr>
</tbody>
</table>

### Table-6 Distribution of the study groups according to the clinical improvement

<table>
<thead>
<tr>
<th></th>
<th>I. Group</th>
<th>II. Group</th>
<th>III. Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n:50)</td>
<td>(n:52)</td>
<td>(n:49)</td>
</tr>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>improvement</td>
<td>36(%72)</td>
<td>42(%80.7)</td>
<td>34(%69.3)</td>
</tr>
<tr>
<td>Failure</td>
<td>14(%28)</td>
<td>10(%19.3)</td>
<td>15(%30.7)</td>
</tr>
<tr>
<td></td>
<td>p&gt;0.05</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In our study the most common complaints were fever, cough and headache. Families tend to bring their child when he/she has fever otherwise they wait for recovery. Night cough especially alarms the family. The mean age (8.33 year) of our study group was appropriate for expressing their complaints by themselves.

Williams et al. asked for symptoms of acute sinusitis in a prospective study of 221 adult patients and found out that the most common complaint was fatigue (62%) (8). In our study the most common complaint was fever (95%). Fatigue probably couldn't be expressed by our patients because they are in the childhood age group. Lindbaeck et al. found out that in 357 adult patients clinical diagnosis of sinusitis is generally correct and erythrocyte sedimentation rate, C reactive protein and leukocyte count has a limited value in diagnosis of sinusitis. We also found leukocytosis only in 33.8% of the patients (9). Conrad et al. published a review and determined that childhood sinusitis is caused by S. pneumonia, H. influenza and M. catarrhalis, radiologic examination is unnecessary and the first treatment regimen should be high dose amoxicillin (80-90 mg/kg/day) at least 7 days after the symptom resolution; approximately 10-14 days (10). We used the 14 day standard treatment regimen for amoxicillin since our study population is of a lower socio-economic status.

In a study conducted by Virant, 30-50% of childhood sinusitis patients also have asthma. In these patients aggressive medical or surgical treatments enable
relief of both upper and lower respiratory symptoms in a significant manner. Judicious antibiotic use is also useful for relieving asthma symptoms in these patients (11).

Garbut et al. conducted a comparative study for amoxicillin, amoxicillin-clavulanate, and placebo; and found out no statistically significant difference in treatment effectiveness. This information may make us think that in childhood sinusitis there is no need for antibiotics, but the investigators, used 55 score (congestion, day cough, head or facial pain, colored nasal mucus) (12). They wanted from the parents to score those parameters 0-3. This seems to be a subjective scaling, because parents may exaggerate or minimize the symptoms according to their personality. Williams et al published an article in which 32 studies about adult acute maxillary sinusitis were included. They stated that although recent evidence has been limited, 7-14 days of penicillin or amoxicillin treatment is useful. Additionally they recommended that the balance between the treatment benefit and the adverse effects should be evaluated before prescribing the antibiotic (13). In our study, because we found no statistically significant difference between effectiveness and adverse effects, we may conclude that all the three drugs may be prescribed confidently with respect to this balance. From the three drugs, azithromycin had not only the highest percentage of treatment effectiveness, but also the lowest percentage of adverse effects.

In a meta-analysis (11 studies and 1742 patients), Ioannidis et al studied azithromycin in sinusitis treatment, and found that there were no statistically significant difference between azithromycin and other antibiotics in respect to treatment effectiveness. In that meta-analysis, there were 0.8% drop outs because of the adverse effects (14). In our study we also didn’t find any significant difference between effectiveness and adverse effects of azithromycin and the other drugs, but we had no drop outs because of the adverse effects.

Garcia et al conducted a study in which 78 adult and paediatric patients having acute respiratory system infection were compared for the treatment effectiveness of azithromycin, amoxicillin-clavulanate and cefaclor. They found 97% of azithromycin patients were improved or cured, 85% of amoxicillin-clavulanate and 84% of cefaclor group accordingly. Azithromycin had statistically significant difference in treatment effectiveness than amoxicillin-clavulonic acid and cefaclor (p < 0.02). Adverse effect frequency was 0%; 15%; and 16% accordingly (15). Although antibiotics and the indication of use are not the same, we also found azithromycin as the most efficient one with a percentage of 80.7; but this is not statistically significant. This difference may be caused by the difference between the indications of the antibiotic use (acute respiratory system infection vs. acute sinusitis). The adverse effect ratios were similar in our study. Azithromycin had 7%, amoxicillin had 8%, and cefprozil had 10%.

There are limited studies that investigate the treatment effectiveness of cefprozil in acute sinusitis. In a study conducted by Hedrich et al, it has been shown that in acute otitis media, high dose amoxicillin-clavulanate and cefprozil had equal treatment effectiveness and low adverse effect profile (16).

Arguedas et al. showed similar results in otitis media with effusion, i.e. that cefprozil has an effect equal to amoxicillin-clavulanate, but a lower adverse effect profile (17). Adelglass et al conducted a study in 278 adult patients and compared amoxicillin-clavulanate and cefprozil. They found no significant difference between the treatment effectiveness of the two, but adverse effect frequency is high for amoxicillin-clavulanate (18). We conducted our study in a paediatric age group and found similar results for amoxicillin and cefprozil but cefprozil has more frequent adverse effects than amoxicillin (10% and 8%).

Cassiano determined that short term amoxicillin use (10 days) is as effective as azithromycin use (5 days) in adulthood acute maxillary sinusitis. Short term antibiotic use has advantages in terms of treatment compliance, adverse effect frequency and bacterial resistance (19). Pichichero published a review and stated that short term antibiotic use has similar results with long term use in acute sinusitis (20). We also found out no significant difference between 5 days azithromycin, 14 days amoxicillin and 14 days cefprozil treatment. For childhood sinusitis there is a need for more short term studies.

Brook et al, in one of their reviews listed the indications for referral to an otorhinolaryngologist as treatment failure, immune deficiency, nosocomial infections and disturbance of the general status of the patients (4). In our study we referred the treatment failure group (25.8%) to an otorhinolaryngologist.

Powers, in his study comparing the taste of azithromycin with other antibiotics, concluded that dose interval, treatment duration and the taste of the drug affected the compliance and the clinical outcome. Children preferred azithromycin to cefpodoxime (90% to 52%); and to cefprozil (63% to 33, 1%). Azithromycin is an effective antibiotic, with its taste influencing the compliance and the clinical outcome (21).

At the end of the study “clinical improvement” was evaluated as total (TI), partial (PI) or no improvement (NI) respectively. These figures for amoxicillin were 62%, 10% and 28%, for azithromycin 64%, 17% and 19% and for cefprozil 53%, 17% and 30% respectively.

When total and partial improvements were collectively defined as clinical improvement (CI), the
figures became 72% for amoxicillin, 81% for azithromycin and 69% for cefprozil, the difference of which were not statistically significant.

Adverse effect rates were 8% in the amoxicillin group, 7% in the azithromycin group and 10% in the cefprozil group. These were mild reactions and there was no need to stop the treatment in any patient.

Piccirilo et al found out that first line and second line drugs have similar treatment effectiveness but second line drugs have a nearly two fold cost compared to first line drugs (22).

In our country amoxicillin is the cheapest drug, and azithromycin has two fold and cefprozil has five fold cost. In the paediatric age group sinusitis is a very common disease. Therefore we emphasize that the preference of the cheapest and effective antibiotic is a more realistic and rational treatment policy.

REFERENCES


9) Lindbaeck M, Hjortdahl P, Johnsen ULH. Diagnosing acute sinusitis. J Fam Pract (43);23-7, 1996


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European Journal of General Practice

Philip Evans, President
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Maltese Doctors Graduate in Diploma in Therapeutics (Irish College of General Practitioners)

Adrian Micallef - Family Doctor

On 1st November 2002, 14 Maltese doctors successfully graduated in a Diploma in Therapeutics, carried out by distance learning, organized by the Irish College of General Practitioners. The programme was coordinated locally by Dr. Anthony Azzopardi, MCFD council member and launched on 14th September 2001 under the auspices of the MCFD. The Diploma was open to all general practitioners in public and private medical care but for logistical reasons the number had to be limited to not more than 14 doctors.

This was the third distance-learning programme on Therapeutics organized by the ICGP. The course runs over one academic year and consists of 30 weekly modules, each covering one topic and requiring the doctor to send in answers to a test sheet based on the respective topic. In addition, course participants were expected to keep a learning diary of critical incidents in their practice and to show practical application of the knowledge they acquired on the course. Furthermore, they had to work on and present a project related to one of the topics covered in the programme. The range of topics was very varied, including not only management of the commoner medical problems encountered but also subjects like counseling, complimentary medicine, drugs in sports, uncomfortable prescribing decisions and other relatively unfamiliar areas of interest. Written material was supplied for each respective module which was also available on the ICGP website.

The course also included two workshops, usually held in Ireland but specific arrangements were made for the trainers to come over to Malta instead. The two workshops in September and December 2001 were led by Dr Margaret O’ Riordan and Dr Ailis Ni Riain. The expenses involved in covering the workshops and some of the other course fees were generously shouldered by several local entities.

Not only were all 14 Maltese candidates successful, but one of them, Dr. Sonia Abela, came first from all the 45 participants of the Diploma course. The graduation ceremony was held on 1st November 2002 in Dublin and was attended by 4 of the Maltese doctors. Dr. Sonia Abela was called out for a second appearance to receive an award for first placing in the Diploma course. Later in the evening, the Irish College officials hosted the Maltese doctors to a dinner specially arranged for them. The 14 successful Maltese candidates were: Dr. Sonia Abela, Dr. Saviour Cilia, Dr. Mario Grixti, Dr. Mario Vella, Dr. Marco Rosso, Dr. Michael Borg, Dr. Adrian Micallef, Dr. Lucienne Portelli, Dr. Rudolph Busuttil, Dr. Anthony Azzopardi, Dr. Zaid Teebi, Dr. Angela Sammut, Dr. Andrew Zammit and Dr. Pierre Mallia.

This was the first time that the course has been organized for candidates outside Ireland and it is evident that we made a very positive impression on the College, especially as we even pipped the local candidates to the post! Another feather in the cap for the Maltese family doctor.
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EGPRN is a network organisation within
WONCA Region Europe - ESGP/FM
The EU Doctors' Directives and Family Medicine in Malta

ADRIAN MICALLEF
FAMILY DOCTOR

"General practice/family medicine is an academic and scientific discipline and a clinical speciality with its own educational content, research, evidence-base and clinical activity, oriented to primary care." This is the 2002 European definition issued by the World Organisation of Family Doctors (WONCA). Across Europe, Family Medicine is establishing itself even more strongly as a recognised speciality requiring specific training. In Malta too, Family Medicine is about to undergo significant changes in the way it is to be perceived and practised. The EU accession process that Malta has been involved in has entailed familiarisation with European Union legislation regarding the medical profession, the so-called Doctors' Directives. Furthermore, a number of provisions in these directives have been entrenched in the drafting of the new Health Care Professions Act even before Malta's final position with regards to full membership was decided.

The issues regarding the EU Doctors' Directives and their relevance to Family Medicine in Malta were the subject of last February's winter CPD meeting organised by the Malta College of Family Doctors (jointly with the Medical Association of Malta). A review of the relevant issues is being reproduced hereunder.

The EU Doctors' Directives

The EU law on doctors has been in place since 1975, and was mainly directed at mutual recognition of specialists' qualifications and freedom of movement between Member States of the EU as well as training requirements for specialists. Specific training in general medical practice first features in 1986 as Directive 86/457/EEC. April 1993 saw the ratification of a landmark Directive 93/16/EEC which consolidated all the previous directives and is still considered the basis for legislation regarding the medical profession although updated in 2001 (as Directive 2001/19/EC).

The introductory statement (called the 'preamble') to Directive 93/16/EEC makes specific reference to general practice in the following aspects:

(a) the recognised need for specific training in general medical practice.
(b) The unique role and clinical activity the general practitioner will have, within the framework of healthcare, with this training. It mentions specifically "a more selective approach to the consultation of specialists, use of laboratories and other highly specialised establishments and equipment".
(c) The acknowledgement of the upgrading of status that this training will bring.

The directive is divided into specific sections called Titles, each title dealing with a specific issue pertaining to the medical profession. Title IV deals with specific training in general medical practice. The following articles within this section will have direct relevance to the local situation.

Title IV: Articles 31, 34 – duration and content of specific training in general medical practice

Article 31 states that specialised training in family medicine shall be a full-time course lasting at least 3 years (this was an amendment in 2001 from a 2-year course as in the original directive of 93/16/EEC), over and above the basic medical training leading to the MD qualification. It will be practical rather than theoretically based. The practical instruction shall include at least 3 months in an approved hospital or clinic with suitable equipment and services, and 6 months in an approved general medical practice or centre where doctors provide primary care. It will entail the personal participation of the trainee in the professional activities of the trainer/s. Article 34 lays down the regulations for part-time training stating that 'member states may authorise specific part-time training provided...the total duration of training is not shorter than the full-time course...the weekly duration of part-time training may not be less than 50% of weekly full-time training and...it must include a certain number of full-time training periods, both in the hospital setting and in the approved general medical practice'.

Title IV: Article 36 – for whom training is obligatory and who is exempt

As of 1st January 1995, European legislation has made it a condition in member states that for general medical practitioners to work in national security schemes (the health centre set-up in the Maltese scenario) they must have undergone training to the specifications above. However, each member state has been obliged to exempt from such training doctors established in that country before January 1995, provided that they satisfy certain conditions. Basically the doctor has to provide a certificate from a specially appointed authority stating that that doctor has been effectively and lawfully engaged in the activity in question (in this case family practice) for at least 3
consecutive years of the last 5 years prior to issue of the said certificate (article 9). These are the so-called 'acquired rights', more colloquially termed the 'grandfather clause'.

As regulations currently stand, there is no direct reference in the directives to obligatory training for doctors working in the private sector.

Recognition of qualifications of family doctors between Member states

Mutual recognition between member states of general practitioners is drafted in Article 37 of the 93/16/EEC Directive, and this applies to both obligatory training and acquired rights.

The 2001 amendment addresses two other scenarios in this respect, namely that:

(a) if a discipline is recognised as a speciality in certain EU member states but is not on the specialist list in others, these latter countries will have to recognise the qualifications of the specialists concerned on condition that the qualification has been achieved to the standards required by the Directive (as confirmed by a competent authority) – (Article 42b 2001/14/EC).

(b) Training and qualifications obtained in countries outside the EU will have to be considered by an EU member state if (i) the qualification has already been recognised in another member state OR (ii) the qualification is accompanied by evidence of further training/professional experience in the member state (Article 42c 2001/19/EC). The host country has to decide about recognition within 3 months from submission of the application, and in the case of rejection, there is a right to appeal before the National Courts of Justice.

Competent authorities who will issue/reject certificates – Title V 93/16/EEC

Earlier on, reference was made to specially set up authorities who will issue qualifications and exemption certificates and who will examine certificates/qualifications of people wishing to practice the profession locally. Title V of the Directive stipulates the setting up of such competent authorities within Member States. The local equivalent in Malta will be the Specialist Accreditation Committee (SAC) of which one responsibility will be to accredit doctors to individual specialist registers. Provisions are being made in the Draft Health Professions Act for family medicine to be included in this list of specialist registers and in fact the Malta College of Family Doctors will be having a direct involvement within the activities of the SAC.

Continuing Medical Education (2001/19/EC: Article 9)

Obligation to show that doctors are carrying out continuing medical education is written into the 2001 Directive and states that 'continuing training shall ensure, in accordance with the arrangements prevailing in each member state, that the persons who have completed their studies can keep up with progress in medicine'. The EU has left it up to each member state to decide how this policy is to be implemented. Locally, administrative steps have already been taken to recognise this obligation by providing financial assistance for doctors in Government employment who take the initiative. It is hoped that some equivalent arrangement will be reached as well for doctors working in the private sector.

Other issues

As a result of EU legislation, other issues that will affect the medical profession locally include the Working Time Directive capping the obligatory maximum number of weekly hours a person can work, and the involvement of doctors in pharmacovigilance through the systematic reporting of adverse drug reactions and side effects. For further information on these and other issues the reader is referred to the 'current opinion' section in the Malta Medical Journal Volume 14 Issue 1 Nov 2002.

References:


The Malta College of Family Doctors was founded in 1989; a programme of continuing medical education for family doctors was established in 1990; a Department of Family Medicine within the University of Malta was set up in 2001; the development of a vocational training programme in family medicine was agreed to in 2003.

The Family Doctor in the European Union today is considered as a specialist and needs vocational training to practise as such. The College has gone beyond the 4 areas listed in the 1988 Development Plan to fulfil the aim of its 1998 Policy Document towards upgrading the status of the family doctor. In fact the new Health Care Professions’ Act passed through Maltese Parliament in 2003 ensures that Maltese Family Doctors too will benefit from the specialist status that they so richly deserve.

With thanks to Dr Ray Busuttil, Honorary Secretary 1990-94, for kindly providing details of the College’s first years.

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