Maltese Family Doctor

It-Tabib tal-Familja

A peer-reviewed journal of the Malta College of Family Doctors

VOLUME 14 - ISSUE 01 JUNE 2005

MALTESE FAMILY DOCTOR VOLUME 14 - ISSUE 01 JUNE 2005

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Maltese Family Doctor

The mission of the Maltese Family Doctor is to deliver accurate, relevant and inspiring research, continued medical education and debate in family medicine with the aim of encouraging improved patient care through academic development of the discipline. As the main official publication of the Malta College of Family Doctors, the Maltese Family Doctor strives to achieve its role to disseminate information on the objectives and activities of the College.

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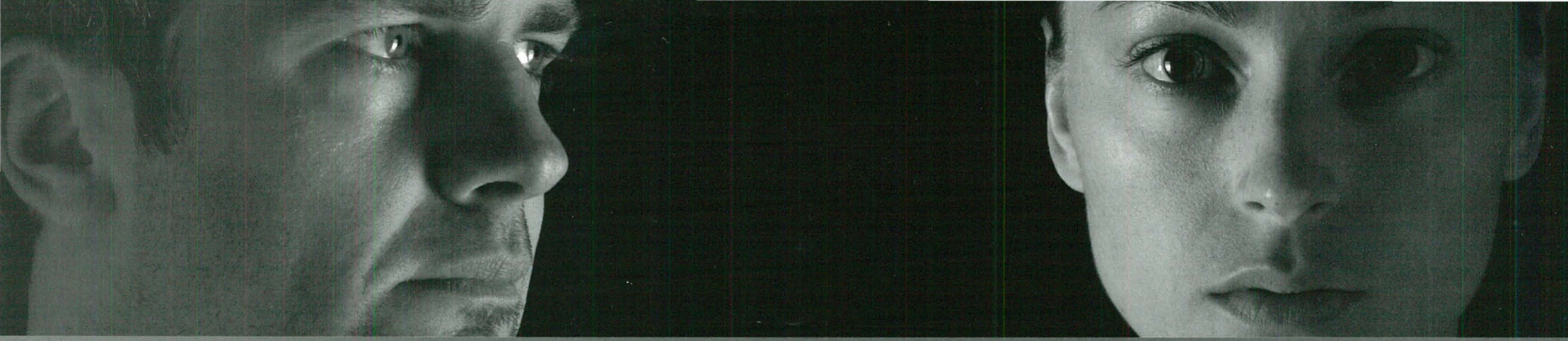

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Why does primary health care matter?

Dr Noel CARUANA

Decades of accumulated experience have shown that it matters to have a primary care-based health system. Countries and their people with good access to primary care do realize a number of health and economic benefits, typically the following:

Evidence of Efficiency

- Fewer tests done, higher patient satisfaction, less medication use and lower care related costs [1].

Evidence of Effectiveness

- Reduced morbidity and mortality caused by pulmonary and cardiovascular diseases [2].
- Better detection of mammary cancer and reduced mortality from cervical and colon cancers [3,4].
- Less use of emergency departments and hospitals [5].

Evidence of Equity

- Reduced health inequalities, particularly for low income families [6].

Despite the disproportionate growth of subspecialties, **primary care doctors still provide most of the care to most patients for most ailments most of the time.**

Holistic medicine necessitates a profound trusting doctor–patient relationship. This model of delivering a service to our patients has been eroded by the set up of what was at the time intended to be an emergency service, the Polyclinic, which however has been expanded for many reasons, to provide a pseudo Family doctor service. This has over the years led to a dichotomy between the Private GP and the state employed GP. Is it perhaps time that this division is closed? Perhaps by evolving a true National Health Service? Our Health economists must take such an eventuality very seriously, because on the eve of opening a high cost Tertiary care money guzzler, there have been no plans for a true functional primary care system.

Private primary care is still very cheap. A medical consultation still costs less than what a washing machine technician would charge you for *looking* at your leaking appliance! Over the years this has led to Family doctors to resort to working more and more and having less and less time to do a good job, to say nothing of their family life.

Keeping yourself abreast with the latest medical advances necessitates that you have time to sit down and read or surf the internet. With increasing patient expectations and more tight fisted legislation, maintaining a Practice will come to be more and more expensive. Market forces may not hold in the healthcare field as some may expect them to. It is important to recognize that what the market will bear may not be what the population can bear when it comes to health care.

The ever-increasing workload experienced by governmental primary care givers is perhaps an indication of this phenomenon.

A new set up for primary care is necessary if we are to witness a truly professional service, where what matters is not merely conceding to public demands, but providing good quality care to address the patients' needs.

The MCFD has since its inception, been working at improving the academic level of Family doctors in Malta. The college on its own and with no external financial aid, has been working at organizing the personal (academic) development of its members for their own and their patients' benefit. The college has won the struggle to include Family Medicine, and rightly so, as one of the Medical Specialties in Malta (see article by Dr Jean Karl Soler in this issue).But what does this mean? And how will it effect the further development of Family Medicine in Malta?

It seems to be an open secret that the government Health sector in Malta is like a time bomb.... Everyone is expecting something to happen, but no one wants to comment on it. One thing is certain is that if Family Medicine is to remain viable in Malta a number of vital decisions have to be taken. Is the government and the public itself, happy to let its people pay more to get a good Family Doctor service which guarantees continuity of care and all the other requisites for good general practice? Doctors struggling with the ever increasing workload at

health centres and public hospitals cannot be realistically expected to do more and more when one looks at the working conditions and salary set up.

It's all to do with (mis)management they say! But who is the director of the whole orchestra? Why is it that the conductor does not consult his musicians even on hearing musical sounds that are jarring and off the beat?! Politicians, Managers and Health Economists please note that a fundamental rule is to have a cooperating workforce, but history has shown that you earn cooperation, you do not force it!

Epidemiology and audits show us whether any particular intervention is effective and to what degree. Are we creating an illusion about the true state of health of our nation ? Are we truly practicing preventive medicine ? Preventive campaigns cost money and are time consuming and yet should be a cornerstone in the work of primary health workers. As Family doctors we should be lobbying for more funds for this use. We have to be aware that for many reasons the Family doctor has been marginalized and has surrendered his authority and policy setting influence to various agencies and authorities. It is necessary to work more to retain the relevance of the Family doctor in our society.

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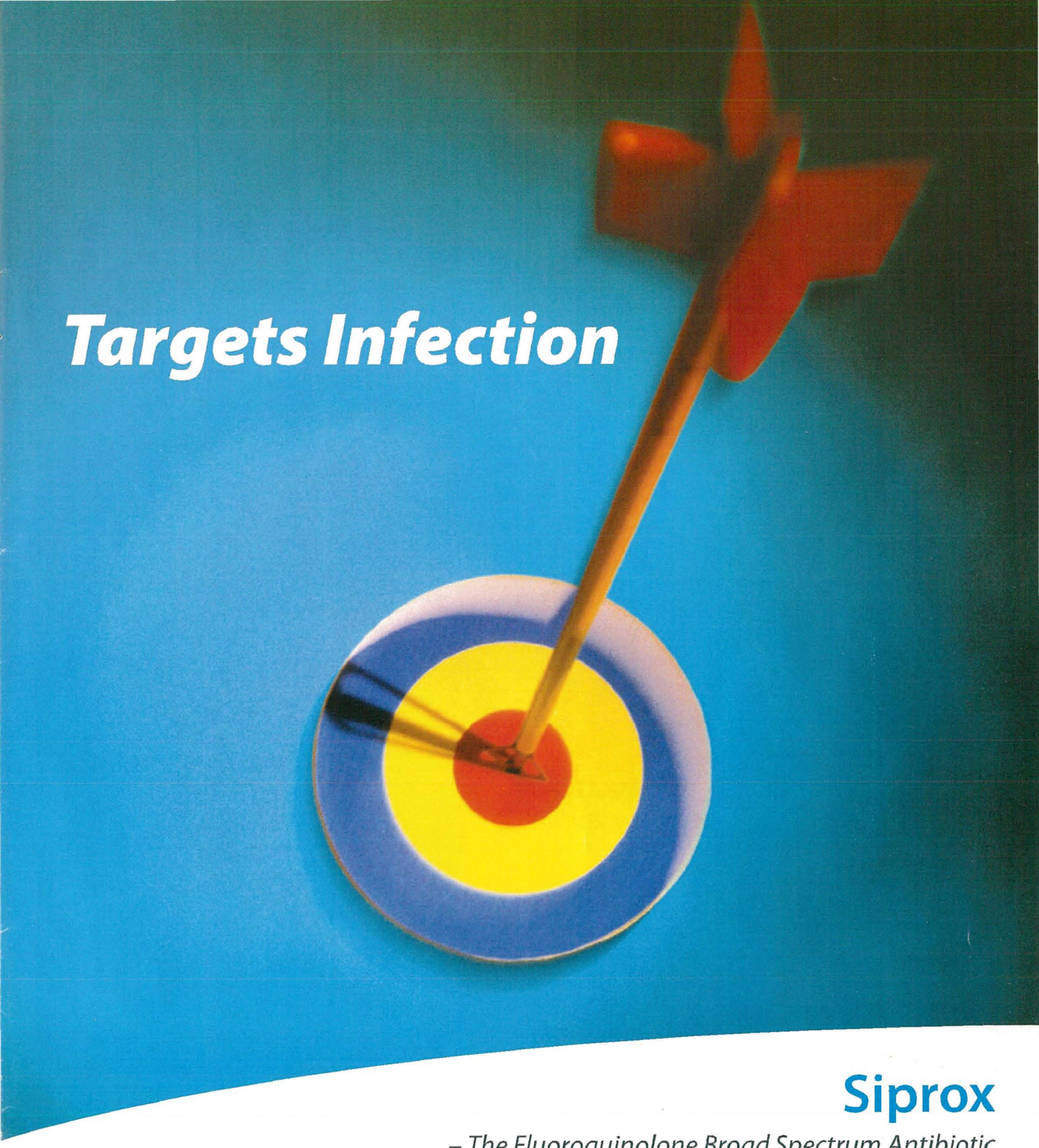
Editor's Note

I would like to take the opportunity to thank my predecessor Dr Jean Karl Soler who was editor of this journal for a number of years.

At a first glance and after going through the rest of this edition, one will notice that there are a number of changes both in the contents and style. As a peer-reviewed journal, it is my intention as the new editor, to make the Maltese Family Doctor, a journal by family doctors for family doctors. This journal is intended to offer a forum for discussion on different areas of family medicine, ranging from epidemiology, research and statistics, to ethical issues and moral dilemmas.

Contributions (both from the national sector and by our colleagues abroad) to this journal are welcome. Review papers, research articles and relevant news items should be sent to the editor by email to: **journalmfd@yahoo.com** or on floppy/ CD in Microsoft Word format to: The Editor, Maltese Family Doctor, PO Box 69, Gzira, GZR 01 Malta.



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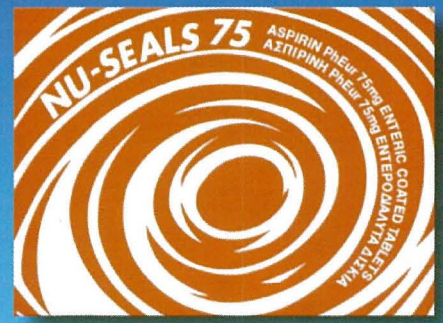

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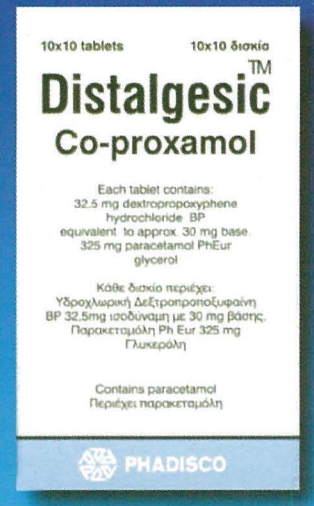

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MCFD-RCGP international course for teachers of general practice 2004

Dr Mario R SAMMUT

Following Malta's accession to the European Union on 1st May 2004, EU Directive 93/16 obliges the introduction of Specialist Vocational Training in Family Medicine in Malta. As a member of the Specialist Accreditation Committee within the Ministry of Health, the Malta College of Family Doctors (MCFD) is responsible for the development of a Specialist Training Programme in Family Medicine for Malta. In anticipation of the set up of this programme, the MCFD, in collaboration with the International Committee of the Royal College of General Practitioners (RCGP), in 2004 organised another 'International Course for Teachers of General Practice' (following that held in 2002-3) to train more teachers to provide this programme.

The Course

An **introductory module** was held on 24 April 2004 at the Forum Hotel, St Andrew's. This was tutored and organised by Dr Doreen Cassar and Dr Mario R Sammut, with the support of Dr Philip Sciortino and Dr Pierre Mallia, all of whom had completed previous Teachers' Courses.

During this orientation one-day workshop, participants were introduced to educational concepts (learning requisites and styles) and reflective practice. As an assignment for the next module, they were asked to complete a reflective diary on how they felt and responded to the orientation day.

The **second and third modules** of the course took place on the 17-21 May 2004 at the Forum Hotel, St Andrew's, and on the 18-22 October 2004 at the Dolmen Resort Hotel, Qawra. Both modules were tutored by Prof Rosslynne Freeman and Dr Marek Jezierski from the RCGP, co-tutored and organised by Dr Doreen Cassar and Dr Mario R Sammut, and supported by Dr Philip Sciortino and Dr Pierre Mallia.

The **second module**, after briefly revisiting the educational concepts introduced in the introductory workshop, then went on to tackle learning cycles, one to one teaching, small group teaching, and formative and summative assessment. Reflective practice was encouraged by holding reflective groups to close each day's work.

Assignments were set for the third module as follows: the design of a curriculum for the GP training year; the preparation of a 10-minute teaching presentation; the recording of a video consultation; the preparation of a 5-minute presentation on something read that prompted further thought and reflection; and the holding of large and small group meetings. In fact 4 large group meetings were held on a monthly basis, while students also met in small groups.

The **third module** then consisted mainly of the presentation of the various assignments, on which constructive feedback was given (with various methods being modelled). Moreover, information was presented on managing the consultation and different consultation models, together with small group teaching and leadership. However, the highlight of this final module was an afternoon of tutorials with medical students where each participant had the chance to experience one-to-one counselling with a student.

Figure 1: Dr Marek Jezierski (standing) in full flow during a group session

Figure 2: Dr Doreen Cassar (left) and Prof Rosslynne Freeman in deep discussion

The Participants

At the end of the third module, MCFD President Dr Pierre Mallia presented a **certificate of successful completion** to the 14 participants: Dr Jurgen Abela, Dr Diana Balzan, Dr Jason J Bonnici, Dr Ron Borg, Dr Anton Bugeja, Dr Noel Caruana, Dr Saviour Cilia, Dr Josianne Cutajar, Dr Patricia De Gabriele, Dr Alessandra Falzon Camilleri, Dr Mark Rosso, Dr Daniel Sammut, Dr Zaid Teebi and Dr Andrew P Zammit.

Follow-up

In order to enhance the **further development** of teaching skills, knowledge and attitudes, participants of both MCFD Teachers' Courses were advised to participate in Continuing Professional Development activities. These include video-analysis of consultations in small groups and the preparation in pairs of a ten-minute presentation on a subject related to GP training based on a piece of art (poem, writing, painting, music, etc). There will also be the opportunity for participants to be involved in the development of the MCFD's Specialist Training Programme in Family Medicine.

A formal decision has yet to be taken regarding any further training modules for participants of both Teachers' Courses held by the MCFD. These could include a **fourth module** on mentoring and appraisal and, after participants would have started active teaching, a **booster module**.

Figure 3: A commemorative group photo, taken at the end of the course, of the participants with the tutors Prof. Rosslynne Freeman (back row, fifth from right) and Dr Marek Jezierski (front row, fourth from right) and the co-tutors Dr Doreen Cassar (front row, third from left) and Dr Mario R Sammut (back row, second from left)

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Membership of the MCFD

In unison with the vision shared by previous councils, the present council has been working on the development of the Membership of the Malta College of Family Doctors. Talks have been carried out with both the Royal College of General Practitioners and the Irish College of General Practitioners in this regard and both colleges have promised their support in the setup of this membership, which is by no means a small task.

In January 2005 five members of the Malta College of Family Doctors attended a three day membership development seminar organized by the Royal College of General Practitioners, which focused on modes of assessment for the membership examination.

Talks have also been carried out with Dr John Howard on behalf of the Royal College of General Practitioners on the possibility of developing the MRCGP(Int) for the local scene.

The college has recently set up a Membership Board and a Curriculum Development Secretariat to work specifically on these initiatives.

Continued medical education:
Hypertension and systolic dysfunction (day case)

Dr Noel CARUANA

Presentation

Mrs Grech, a 61 year lady woman was accompanied to my clinic by her daughter due to progressive dyspnoea. She had enjoyed good health until 3 months previously when she started to complain from exertional dyspnoea with minimal activity. Lately this complaint was accompanied by an increase in her weight and some swelling of her feet. Since the previous week her dyspnoea worsened and she noted orthopnea and some chest discomfort. She had been an ex-smoker since 7 years and did not abuse alcohol. She had also been on antihypertensive treatment for over 10 years but with poor blood pressure control. She was taking atenolol 100mg and hydrochlorothiazide 50 mg daily.

Clinical examination

She was obese (weight 79 kg, height 157cm) and tachypneic at 39 respirations per minute. Her BP was 165/95 mm Hg, with a regular tachycardia at 105 bpm. There were no carotid bruits but the jugular pressure was raised. Cardiac examination showed a laterally displaced apex beat at the sixth intercostal space, a 2/6 systolic murmur and a third heart sound. Lung auscultation revealed significant bilateral crepitations. She had pitting oedema of her legs, with normal pedal pulses. The rest of the examination was unremarkable.

Investigations

A chest X ray showed significant cardiomegaly and pulmonary oedema (Figure 1). On ECG, there was sinus tachycardia and a complete LBBB (Figure 2). Routine haematological and blood chemistry were normal except for an elevated cholesterol (total cholesterol: 7.9mmol/l, LDL: 5.1mmol/l, HDL: 0.98mmol/l) and triglycerides 3.2mmol/l.

Management

This lady was treated with an initial dose of IV frusemide and started on oral ACE inhibitor (enalapril 10mg daily), a diuretic (bumetanide 2mg daily) and aspirin 75mg daily (which was changed to a coumarin after the echocardiogram confirmed regurgitation). She was referred to a cardiologist who performed an echocardiogram which showed marked left ventricular hypertrophy (LVH), septum 12mm, posterior wall 11mm and left ventricle end-diastolic diameter 70mm. There was also evidence of marked global systolic dysfunction, with an ejection fraction of about 22% . There was also moderate mitral regurgitation and mild tricuspid regurgitation. Systolic pulmonary pressure was 48 mm Hg.

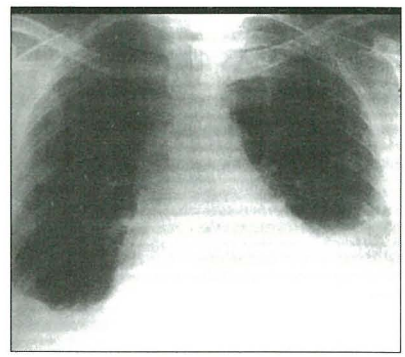

Figure 1

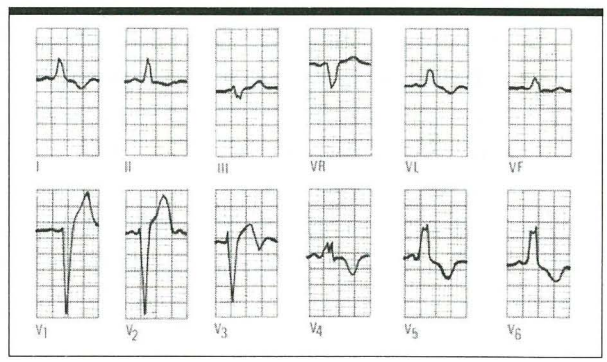

Figure 2

At a second review two weeks later, she was found to have no tachypnoea and no chest discomfort and a BP of 145/ 90. The ACE inhibitor dose was increased to 20mg daily and the diuretic dose was decreased to 1mg daily, a statin was also added in view of hypercholesterolaemia. An angiogram was booked to rule out ischaemic disease.

Questions

1. How does congestive heart failure develop during hypertension?
2. How could hypertensive heart disease be detected in such a patient?
3. What is the best treatment protocol and the prognosis for this patient?

Answers on page 41 After reviewing the answers you can claim 1 CME point by quoting code MFD/CME 001 on your application for accreditation.

The official recognition of family medicine as a speciality

Dr Jean Karl SOLER

The Malta College of Family Doctors was set up in 1989 to improve the status of general practice in Malta. Since then there have been many important developments which have helped us move towards this aim, such as the publication of a journal of Family Medicine, the setting up of a Department of Family Medicine at the University, the setting up of a formal Continuing Medical Education programme, and the institution of Vocational Training for Family Medicine. However, the jewel in the crown would have had to be the official recognition of Family Medicine as a speciality at a par with other specialities.

The speciality of Family Medicine

This objective was difficult to achieve without strong political support. Family Medicine's academic and clinical status was not highly regarded by sister medical specialities, possibly because the discipline's community base was not seen to provide the same scientific and research rigor as institutional medicine. Sister Colleges in other European countries have in fact experienced similar problems.

The recognition of Family Medicine as a Speciality at par with other medical specialities required external pressures far more powerful than those our small College could muster. This pressure came with Malta's European Union membership. Since May 2004 the mutual recognition of medical specialities was now a requirement. This forced changes in the Health Care Professions Act (HCPA) that included the institution of a Specialist Accreditation Committee (SAC) and the setting up of a number of Specialist Registers. This in turn provided an opportunity that was not to be missed.

The rough road to recognition

The Malta College of Family Doctors was represented on the SAC in all proposed drafts of the law, but the inclusion of Family Medicine with the other specialities was a much more controversial issue.

The fact that many junior hospital doctors do in fact practise private general practice on a part time basis generated much concern that such a practice could be affected by the new legislation. Furthermore, a significant number of College members, Council members and doctors in the Department of Health considered that Vocational Training was to become a requirement to practise general practice and family medicine both within the Government national health care system and in the private sector. Consequently, many doctors viewed the formal recognition of Family Medicine, together with the institution of vocational training, as a threat to their informal status as part-time GPs. Unfortunately pressures from this group of doctors triggered an attempt to negatively influence the recognition of Family Medicine as a Speciality by the SAC.

The struggle to have Family Medicine fully recognised at par with its sister specialities involved two crucial stages.

Firstly, the College conceded that Vocational Training would be required only for doctors who would apply to work in the Government Health Centres after Malta's EU accession. Thus those who would not qualify for the Specialist Register of Family Medicine by acquired rights before the 1st of May 2004 would still be able to practise as a GP part-time without requiring further training. Even those who qualified after the 1st of May would be able to continue to do this, since otherwise a doctor thus qualified could not practise at all unless employed in a Government training post in primary or secondary care. This was considered an untenable situation, especially since Vocational Training systems have still not been set up, and the new system might not be able to take all the doctors who wanted to practise as GPs.

However the ideal situation should still be Vocational Training for all Family Doctors, something that the College aims to implement in the future when resources allow this. Training resources must be developed to allow us to offer formal training to all doctors who want to practise as Family Doctors.

The second major step was the recognition of acquired rights for all doctors qualified before Malta's EU accession. In the past, anyone who had a basic medical degree (MD) could practise as a GP. This right could not be withdrawn simply because of Malta's accession to the EU, and the recognition of Family Medicine as a speciality could not therefore impede these doctors from practising as GPs in the future. The College Council consulted two legal experts in EU legislation, and their advice was to recognise that all those who held the MD degree before Malta's accession to the EU had the acquired right to practise as a GP, and also to work in Government service as GPs in future.

However, the SAC had the right to decide what the qualifications for Specialists in Family Medicine should be, independently of one's acquired right to practise as a GP.

Whilst these two "problems" were being solved, another objection arose concerning the fact that in a number of European countries Family Medicine and General Practice were not considered specialities at a par with other medical specialities. In fact some European countries had a general list (for those holding the MD degree or equivalent), a GP list for qualified GPs, and a list of medical registers for the other specialities. The new Maltese HCPA did not allow for this option, and the only alternative was to include Family Medicine with the list of specialities without any distinction. The College did use various UEMO (European Union of General Practitioners) materials, generously given to us by the MAM, to support these arguments. In fact many European countries have recognised Family Medicine as a speciality at par with other medical specialities, and this is the road that Malta has chosen to take.

The entry requirements for the register of Specialists in Family Medicine

The final draft of the new Act was finally approved in Parliament with Family Medicine firmly rooted in the list of Medical Specialities.

One final hurdle was to agree on the actual formal requirements for an individual's entry on the register of Family Medicine. It was clear from study of the EU directive 93/16, which now had the weight of a Maltese law, that mutual recognition of local and foreign GP status would depend on this register. Our legal advisers again confirmed this.

Malta could recognise whichever acquired rights it chose. However, mutual recognition of degrees was not an option we could choose not to take. Therefore, if we imposed an acquired rights clause on local doctors that was more stringent than that recommended by the EU directives, we would then create an anomaly. We would then have to accept foreign applicants whose qualifications complied with the directive but would not accept Maltese doctors who were equivalently qualified. If our acquired rights clause was too lenient, then we could have the situation where doctors on the Maltese register might be refused the right to practise in another EU state. All Colleges and Associations on the SAC eventually agreed that the best choice was to use criteria that were as close as possible to the EU93/16 requirements.

It was clear that there were two groups of medical graduates to consider.

- Those doctors who qualified as doctors of medicine and finished their post registration training (housemanship) before the 1st May 2004 could be entered into the register of Specialists in Family Medicine on the strengths of their acquired rights. Whether they are entered in the register or not, they have an acquired right to call themselves general practitioners and practise as such within or without the Government Health Care system.
- Those doctors who qualified as doctors of medicine and finished their post registration training (housemanship) after the 1st May 2004 could only be entered into the register of Specialists in Family Medicine further to specific training in general practice. For this group three years of formal Vocational Training is a requirement.

The choice of a defined acquired rights clause was difficult. The EU 93/16 document detailed exact requirements for training in each speciality, but little was specified with respect to acquired rights except the content of basic medical training and that each country was allowed to specify its own requirements. The directive did however accept the principle of part time training (not less than 50% full time equivalent) and did relate experience to training with the general formula that two years of full time experience was equivalent to one year of full time training. The duration of Vocational Training (VT) for General Practice (GP) was also stipulated at three years full time in the latest amendment of the directive (previously two years).

Seemingly, then, three years of full time training, or six years of full time experience was required, and if one were to work part time at 50% hours, then twelve years experience in GP/Family Medicine would be equivalent to the current requirements for VT.

However there was general agreement between College members that this seemed to be too much. In fact the HCPA does contain a clause that equates full time experience to full time training on a one to one basis, and furthermore an acquired rights clause should not be related to a VT requirement that only came in to force in 2003. As such, the College Council decided to ask for three years full time GP/Family Medicine experience to qualify an individual for entry in the register of Specialists in Family Medicine by acquired rights.

To allow individuals to accumulate this experience if they had not had opportunity to do so in the past for various reasons, all those who have had significant experience in GP/Family Medicine before the 1st May were given an extension of their "training" by experience till 2010 on the basis of EU93/16 allowing training commenced before accession to continue unchanged. In fact, this principle of training by experience extended till 2010 was accepted by the SAC on the college's proposal to apply to all specialities.

A formal statement of these requirements was passed through an Extraordinary General Meeting of the Malta College of Family Doctors in 2004. This document has since been posted on the website (www.mcfd.org.mt).

The document's aims and objectives are listed below, followed by a summary of the status of doctors fully qualified and trained (MD + warrant) before or after Malta's accession to the EU. For the full text please refer to the College website.

MCFD Policy Document on the Specialty of Family Medicine in Malta

Aims

The aim of this document is to define the academic and clinical basis of Family Medicine as a Specialty, promote the development of the Specialty of Family Medicine and promote quality standards for Vocational Training for Family Medicine.

Objectives

This document will:

- Define Family Medicine
- Define the requirements for inclusion in the Specialist Register of Family Medicine (SRFM), either by past work experience or through accredited training
- define the requirements of a quality Vocational Training Programme (VT) for Family Medicine.

Doctors in legal and effective practice before 01/05/2004

1. GP practice in Malta

- MD Malta and warrant confers acquired right to work as a general practitioner.
- According to Malta-EU accession treaty he/she can call him/herself a General Practitioner, "Tabib tal-Familja" or a Family Doctor even if not entered on the Specialist Register of Family Doctors.
- Can work as a GP in the Health Centres and National Social Security system (may require modification of HCPA).

2. Mutual recognition of GP status in another EU country

- 5,500 hours or six years training required for MD recognition, which we have in Malta. Otherwise certificate from Medical Council stating that applicant has been in legal and effective practice for three consecutive years in the five before the date of issue of the certificate.
- An EU country where applicant applies for work as GP may ask for a certificate of completion of training as a GP or a certificate of additional experience (2 years of experience in lieu of one year training – 6 years in lieu of three years VT) to make up for "missing" training.

The SAC would ask for proof of additional experience to issue a certificate of compliance for those in the Specialist Register of Family Medicine. Experience under supervision (e.g. 6 months working as an SHO or in a health centre) or academic development (2 years MCFD CME, or conference presentation, or publications).

3. Entry into Specialist Register of Family Doctors

- MD Malta + Warrant before 01/05/2004 **and either**
- 3 years F/T (40 hour week) GP/Family medicine work (health centre or private; clinical, academic or administrative) **or**
- Part-time GP/FM work as above, minimum 20 hours per week to equate with total hours above (e.g. 20 hours per week GP/FM work =50% time = 2X (6years) work experience to qualify) **or**
- 6 months to maximum 1 year SHO grade hospital attachments (in the departments of General Medicine, Paediatrics, Obs & Gynae, Psychiatry, E&A, ENT, Ophthalmology, or Dermatology; maximum three months in any one) plus 2.5 to 2 years, respectively to total three years, full or part time GP/FM work (minimum 20 hours per week) to equate to same total hours as three years full time GP/FM at 40 hour week. However, 6 months to one year of the latter GP/FM work ***must be full time(40 hour week minimum)*** to allow use of equivalent period of hospital attachments in lieu of GP/FM work.

Doctors in legal and effective practice after 01/05/2004

1. GP practice in Malta

- MD Malta + Warrant allows them to enter the Medical Council general MD list.
- Can work as a GP privately, but not in Health Centres and National Social Security system without formal Vocational Training.
- Can only be entered in the Maltese Register of Specialists in Family Medicine after formal Vocational Training.

2. Mutual recognition of GP status in another EU country

- 5,500 hours or six years MD degree, plus certificate of completion of vocational training. This would have to be VT as above in the case of training in Malta.

3. Entry into Specialist Register of Family Doctors

- MD Malta and Warrant and Vocational Training certificate as above.

Dr Jean Karl SOLER MD

Family Doctor
Executive Board Member, European General Practice Research Network
Member, WONCA International Classification Committee
Secretary for International Affairs and Research,
Malta College of Family Doctors

Email: jksoler@synapse.net.mt

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Malta College of Family Doctors

CPD Programme June - December 2005

Forthcoming Events

July	Summer CPD Meeting Tackling Acute Musculoskeletal Problems in Family Practice
October, 1st/ 2nd Friday	Annual General Meeting
October, 1st/ 2nd Saturday	Membership Development Day *(Subject to change)*
October 11th	Hepatitis A, B & C* *Dr Tonio Piscopo*
October 25th	HIV/AIDS* *Dr C Mallia Azzopardi*
October 29th	Autumn CPD - Respiratory Update
November 8th	Influenza Pandemic Surveillance* *Dr T Melillo*
November 29th	Vaccine Preventable Deseases* *Dr C Barbara*
December 6th	Leptospirosis and Typhus* *Dr C Gauci*

**Sequence is subject to change*

Secretary's report of the College's main activities in 2003-2004

Dr Noel CARUANA

1. Council Set up

Following the Council elections, Council posts were assigned as follows during the first council meeting:

- Dr Pierre Mallia- President and Secretary for Ethics
- Dr Andrew P Zammit – Vice President
- Dr Noel Caruana - Honorary Secretary
- Dr Michael Cordina - Honorary Treasurer
- Dr Michael Borg – College Registrar
- Dr J.K. Soler – Secretary for Research and Publications
- Dr Mario R. Sammut – Secretary for Education
- Dr Savior Cilia – Secretary for Information and Communications
- Dr Anthony Xuereb – Member
- Dr Anthony Azzopardi - Member
- Following the resignation of Dr Azzopardi, Dr Philip Sciortino was by-elected

The post of The Secretary for Quality Assurance was vacant until a suitable candidate was to be nominated.

Doctors Jurgen Abela, Mario Grixti and Adrian Micallef were co-opted members of the council during the first council meeting. Subsequently Dr Mario Grixti was elected council member following the resignation of Dr Wilfred Galea.

It was also decided that the following subcommittees would be set up to facilitate the working of the Council. It was stressed that the aim of the council would be to involve the college members as much as possible. The subcommittees set up were:

1. Statute subcommittee
2. Research subcommittee
3. Ethics subcommittee
4. SAC subcommittee
5. Education Subcommittee

In October 2003 Dr Adrian Micallef was co-opted as Secretary for Quality Assurance.

2. MCFD-RCGP Teachers' Course

The second Teachers Course. It was decided by council that a second Teachers course was to be organized. It was to be open to all college members. Preparatory work involving contacts with the RCGP started in October 2003. The members were asked to express their interest in participating in an eventual Course through mailing of information and through the Newsletter (October 2003) and the College's website.

Following the encouraging response, a call for application was mailed to the members in February 2004. There were 19 applicants of which 14 eventually accepted to participate in the two, five-day Teachers' Course. The first module was held in May 2004 with the second module being held in October 2004.

Following approval by members at the EGM in April, the College contributed to part of the expenses, with the rest of the cost being paid by the participants.

3. MMCFD – RCGP (INT.)

The College has been studying the issue of developing a locally based Membership, for a number of years. During the last EGM, members approved the Council's proposal for the accreditation of the MRCGP(Int) in Malta. Since then the College President has been discussing the issue with Dr. John Howard - Chairman of the International Committee, and matters have been evolving leading to a meeting in London in January 2005 where five Council members have attended a two day seminar on Assessment test development in the MRCGP(Int).

4. Family Medicine as a speciality in the Health Care Professions Act

With the set up of the Specialist Accreditation Committee and in line with the agreement between the Government and the College representatives during a meeting with the Dr L Deguara, Minister of Health and Dr R Busuttil, Director General of Health, Family Medicine was to be listed under such name in the list of specialties in the HCPA.

A Specialist Accreditation Subcommittee was set up in October 2003 and was asked to draw up a document about the Specialty of Family Medicine in Malta, which was subsequently presented and approved, at the EGM in April 2004,

In January 2004, the College was officially requested to submit its credentials to the SAC and propose its criteria to be used for eligibility in the Specialist Register. The College Council through its SAC sub-committee attended the various SAC meetings.

The SAC(government appointed body) issued applications for accreditation in March 2004. The College did its best to inform its members of the closing date due to the short notice given by SAC.

The SAC sub-committee (a College's committee) consulted with two lawyers in drawing up the criteria so as to be as lawful and as inclusive as possible for the benefit of its present and future members. The criteria were presented at the EGM in April 2004 and were approved following a vote by the members present.

5. Continuing Professional Development Programme 2003-2004

- The **Autumn 2003 CPD meeting** could not be organized at such short notice after the set up of the new Council. In October the MCFD in collaboration with the Irish College of General Practitioners, organized a workshop for Family Doctors: **Brief Intervention Training in smoking cessation.**
- The **Winter 2004 CPD** meeting involved a number of presentations by Family Doctors and lectures by Dr Vicky Mifsud and Professor Albert Fenech at a one day seminar entitled "Cardiovascular Disease in Family Practice" This format was in line with the results of a questionnaire performed by the College amongst its members.
- The **Spring 2004 CPD** meeting consisted of six evening meetings spread over six weeks. The CPD sessions were entitled "Antimicrobial Chemotherapy in Family Practice". These lectures were delivered by Dr Paul Cuschieri , Consultant Microbiologist.
- The **Summer 2004 CPD** meeting involved a one evening session entitled "Chronic Pain management" on June 25th.
- The Malta Family Practice Research Network in collaboration with MCFD organized a one day "**Symposium on Research in Family Practice**" on Saturday 3rd July 2004.
- Dermafest 2004 was organized as the **Autumn 2004 CPD** meeting by the college and the Maltese Association of Dermatologists and Venerologists in October 2004

The College is in the process of setting up a number of CPD initiatives, which include:

1. A Diploma in Family Medicine
2. Membership by Examination of the Malta College of Family Doctors.
3. International Membership of the Royal College of General Practitioners.
4. Specialist/ Vocational Training Programme in Family Medicine.

Other CPD projects under the auspices of the MCFD include :

5. Masters in Primary Care and General Practice (in collaboration with the University of Ulster)
6. Diploma in prevention in General practice (in collaboration with the Irish College of General Practitioners).

6. Local News

- In **November 2003** the Council decided to organize an Annual College Dinner for all College members. The aim of this annual event is to foster a sense of collectivity amongst College members. The event was on 29th November at Is-Sajjied Restaurant in Marsaxlokk, the turnout was encouraging and a repeat is being organized on an annual basis.
- The College's new website was launched in January 2004, due to termination of the previous site. The new website is intended as a communication site and supplements the monthly Newsletter.
- **January 2004:** Council approves the Document drawn up by the Sac- subcommittee " Specialty of FM in Malta". The President and Vice President attended a meeting with the Director General of Health and the Director of Primary Health Care to discuss issues related to the Second Teachers Course. The Government stated that there were no funds available to sponsor a second teacher's course.
- **February 2004:** Council members attended two workshops which were organized with the intent of allowing discussion on the setting up of the Diploma in family Medicine and on the organization of the Membership in the coming months. MCFD issues call for applications in its newsletter and on the website.
- **March 2004:** Official Mailing address set to be the PO. Box address at Gzira Post office . This was done to redress confusion of having two addresses. All mail is eventually redirected to The Professional centre.
- **7th April 2004:** An **Extraordinary General Meeting** was called for members to approve the document that was to be presented to the Specialist Accreditation Committee. The members were also asked to approve the Second Teacher's Course and to decide on Council's proposal for the way in which the course was to be funded. Both issues were approved by the majority of those present. The draft of the proposed **new statute** was made available to the members via the College's website. At the EGM the majority of members expressed the wish that the present Statute would be amended and not replaced completely. The Statute sub-committee is working on this new initiative.
- **17th April 2004:** Council approves Drs Doreen Cassar and Dr. Mario Sammut as the Second Teachers' Course coordinators, following their nomination by Dr J Howard. The Council also discussed the need for a Booster course programme as recommended by the RCGP, to be set up for Teachers on a regular basis in the not distant future. The Secretary of the Education subcommittee made contacts with Teachers from the first group to obtain their feedback on an eventual Booster course.
- **5th May:** Council approves the purchase of a Dell PowerPoint projector : This equipment is deemed necessary for the current and future use of the College, especially since hiring of this equipment at College's CPD meetings was getting more expensive.
- **1st July:** Dr Soler as the College's representative at the SAC subcommittee informed Council that the SAC had accepted the College's criteria for inclusion in the Specialist Register as had been approved at the EGM following minor adjustments after discussions at SAC. This news was welcomed by all members present.

7. International News

- **December 2003:** Dr M Sammut as College representative attended the Europrev Meeting in December, funding his expenses personally.
- **January 2004:** Council recommends that Dr. M Sammut, Dr P Mallia and Dr J.K. Soler apply for membership in Euract to ensure continued representation of the College.
- **February 2004:** Dr M Sammut signed Convention on Tobacco control on behalf of College. Dr. J.K. Soler attended the European Wonca Meeting in the Netherlands. He acted as representative of the College even though funding all expenses himself.
- **April 2004:** College is invited to attend a Euract Conference for Teachers which is to be held in September 2004 in Denmark.
- **October 2004:** A European General Practice Research Network meeting was organized in Malta.

8. Membership

College membership presently stands at **220.**

9. College journal and newsletter

The College Journal It-Tabib tal- Familja is being issued twice yearly in June and December.

The MCFD Newsletter continues to be sent monthly exclusively to college members, and includes local and international news for the benefit of the Family Doctor.

The previous journal editor Dr Jean Karl Soler informed council that he wished to resign from Editor of the journal. A call for interest in the post of editor was issued . Dr Noel Caruana was approved as new Journal Editor in December 2004.

Contributions to both the Journal and Newsletter are welcome and are to be addressed to the Editor on journalmfd@yahoo.com and College secretary on the college's email address.

Vocational Training

The World Health Organization has adopted the position that every developed health care system must depend on the quality of primary health care for improving health outcomes.[1,2] Following Malta's entry into the European Union, Malta has bound itself to Directive 93/16 which stipulates the need for the setup of Vocational Training for General Practice.

One year on, this training programme has still not started. The college has prepared two groups of doctors who have been trained in collaboration with the RCGP, to facilitate new, prospective general practitioners during their vocational training.

The college welcomes and congratulates Dr Mario Sammut on his recent appointment as the national coordinator of the Vocational Training scheme in the Department of Health. However it notes with regret that the appointments of Teachers have not yet been published. The Vocational Training scheme cannot start functioning without these teachers, who have been trained by the college to assist in vocational training. The college augurs that the Health Department authorities remedy this situation promptly.

1 World Health Organisation. A charter for general practice/ family medicine in Europe. Copenhagen :WHO Europe, 1995.
2 Starfield B. New Paradigms for quality in primary care. British Journal of General Practice. 2001; 51:303-309.)

Five steps in the management of high blood pressure

Dr Saviour CILIA

Check up for high blood pressure (HBP) is one of the most common encounters in general practice. The prevalence of hypertension increases with advancing age to the point where over half of the people 60-69 year of age and about three-fourths of those over 70 years of age are affected. The primary goal of treating patients with HBP is to prevent complications and reduce the long-term total risk of cardiovascular morbidity and mortality. This requires treatment of all the reversible risk factors identified (smoking, dyslipidaemia or diabetes) and the appropriate management of associated clinical conditions, besides treatment of the raised BP per se.

During the last few years numerous international guidelines on the management of hypertension have been proposed in an effort to improve our approach in managing HBP [1-6]. But these guidelines do not agree amongst themselves as they cater for different populations and give different importance to different studies. This article is an attempt to look at these guidelines and try to adapt them to the local scene in five simple steps.

Step 1: Blood Pressure Measurement

Historically more emphasis has been placed on diastolic (DBP) than systolic blood pressure (SBP) as a predictor of cerebrovascular and cardiovascular disease. Nevertheless, observational studies [7,8] confirm a direct and independent relationship between SBP and DBP and risk of end organ damage. Of importance is the fact that SBP rises throughout the adult age range whereas DBP peaks at about age 60 years in men and 70 years in women, and falls gradually thereafter [9,10]. This fact identifies elderly patients with isolated systolic hypertension as being at particularly high risk. Thus, contrary to what was previously thought, SBP is considered by many to be a better predicator than DBP of cardiovascular disease. In practice, both SBP and DBP should continue to be used for the purposes of definition and classification (Tables 1and 2), risk assessment, and guidance of treatment thresholds of hypertension (Table 4).

BP is characterized by large variations both within and between days. Therefore, the diagnosis of hypertension should be based on multiple BP measurements, taken on separate occasions. If BP is only slightly elevated, repeated measurements should be obtained over several months. If a patient has a more marked BP elevation, evidence of hypertension-related organ damage or a high cardiovascular risk profile, repeated measurements should be obtained over shorter periods of time, such as weeks or days.

BP can be measured by the doctor or by the nurse in the clinic, by the patient at home, or automatically over a 24 hour period.

Category	Systolic	Diastolic
Optimal	<120	<80
Normal	120–129	80–84
High normal	130–139	85–89
Mild hypertension Grade 1	140–159	90–99
Moderate hypertension Grade 2	160–179	100–109
Severe hypertension Grade 3	≥ 180	≥ 110
Isolated systolic hypertension	≥ 140	≥ 90

Table 1: WHO/ESH Classification of BP levels (mmHg)

Clinic BP measurements

BP can be measured by a mercury sphygmomanometer or other non-invasive devices (auscultatory, oscillometric or aneroid devices). When measuring BP, care should be taken to:

- Allow the patients to sit for several minutes in a quiet room.
- Take two measurements spaced by 1–2 min.
- Use a standard cuff (12–13 cm wide and 35 cm long) but have a larger and a smaller cuff available for fat and thin arms, respectively.
- Have the cuff at the heart level, whatever the position of the patient.
- Use phase I and V (disappearance) Korotkoff sounds to identify SBP and DBP respectively.
- Measure BP in both arms at first visit; take the higher value as the reference one.
- Measure BP 1 and 5 min after assumption of the standing position in the elderly and diabetic patients, for orthostatic hypotension.
- Measure pulse rate for 30 seconds after the second measurement in the sitting position.
- Clinicians should avoid unnecessarily frequent BP check to worried well patients as these give false reassurance (Box 1).

Home BP measurements

Self-measurements of BP at home can provide information on BP on different days in settings as close to daily life conditions as possible. These values have been shown to have no white-coat effect and to be more predictive of the presence and progression of organ damage than are clinic values [11]. Therefore, home BP measurements for suitable periods before and during treatment can also be recommended because this relatively cheap procedure may improve patient's adherence to treatment [12].Care should be taken to:

- Advise only the use of validated devices (wrist devices are not validated) and semi-automatic rather than mercury sphygmomanometric devices should be recommended;
- Instruct the patients to make measurement seated after several minutes of rest, and inform them of spontaneous BP variability;
- Avoid excessive number of measurements and ensure that some are made before drugs are taken to provide information on duration of the treatment effect;
- Note that normality values are lower for home compared with clinic pressures (Table 2);
- Instruct patients to keep proper record of the measured values and to avoid self-alterations of the treatment.

Ambulatory BP measurements

Several devices are available which permit the automatic monitoring of BP in patients allowed to conduct a near normal life. It has been shown that ambulatory BP correlates with hypertensive target organ damage and predicts the cardiovascular risk more closely than clinic BP [13,14]. Ambulatory BP is usually several mmHg lower than clinic BP (Table 2).

24-hour ambulatory BP monitoring may be considered of additional clinical value, but the technique and its cost may limit its use in routine BP check.

Step 2: Assessment for Risk factors

Diagnostic procedures are aimed at identifying secondary causes of hypertension and evaluating the overall cardiovascular risk by searching for risk factors, target organ damage and accompanying clinical conditions. The diagnostic procedures comprise medical history, BP measurements, physical examination and investigations.

Guidelines for family and clinical history

A comprehensive family history should be obtained, with particular attention to hypertension, dyslipidaemia, diabetes, coronary heart disease, stroke, or renal disease.

1. Duration and previous level of HBP
2. Indications of secondary hypertension:
   (a) family history of renal disease (polycystic kidney)
   (b) renal disease, urinary tract infection, haematuria, analgesic abuse (parenchymal renal disease)
   (c) drug/substance intake: oral contraceptives, liquorice, carbenoxolone, nasal drops, cocaine, steroids, non-steroidal anti-inflammatory drugs, amphetamines, erythropoietin, cyclosporin
   (d) episodes of sweating, headache, anxiety, palpitation (phaeochromocytoma)
   (e) episodes of muscle weakness and tetany (aldosteronism)
3. Risk factors:
   (a) family and personal history of hypertension and cardiovascular disease
   (b) family and personal history of hyperlipidaemia
   (c) family and personal history of diabetes mellitus
   (d) smoking habits
   (e) dietary habits
   (f) obesity; and amount of physical exercise
   (g) personality
4. Symptoms of organ damage:
   (a) brain and eyes: headache, vertigo, impaired vision, transient ischaemic attacks, sensory or motor deficit
   (b) heart: palpitation, chest pain, shortness of breath, swollen ankle
   (c) kidney: thirst, polyuria, nocturia, haematuria
   (d) peripheral arteries: cold extremities,intermittent claudication

	SBP/DBP (mmHg)	Recommended follow-up*
Optimal BP	<120 / <80	1-2 years
Normal BP	120-129/80-89	6-12months
Mild HT	140-159/90-99	1-3months
Moderate HT	160-179/100-109	1-4 weeks
Severe HT	≥180 / ≥110	Immediate treatment
BP treated & controlled	120-140 / 80-90	3-6 months*

** Modify the scheduling of follow-up according to past BP measurements, cardiovascular risk factors, target organ isease, or concomitant conditions*

Box 1: Recommendations for follow-up BP check

	SBP	DBP
Clinic BP	140	90
Home (self) BP	135	85
High normal	130–139	85–89
24-hr ambulatory BP	125	80

Table 2: BP thresholds (mmHg) for definition of hypertension with different types of measurement

5. Previous antihypertensive therapy: drugs used, efficacy and adverse effects
6. Personal, family, and environmental factors

Guideline for physical examination

In addition to BP measurement, physical examination should search for evidence of additional risk factors (in particular abdominal obesity), for signs suggesting secondary hypertension, and for evidence of organ damage.

1. Signs of secondary hypertension and organ damage:
   (a) Features of Cushing syndrome.
   (b) Skin stigmata of neurofibromatosis (phaeochromocytoma).
   (c) Palpation of enlarged kidneys (polycystic kidney).
   (d) Auscultation of abdominal murmurs (renovascular hypertension).
   (e) Auscultation of precordial or chest murmurs (aortic coarctation or aortic disease).
   (f) Diminished and delayed femoral and reduced femoral BP (aortic coarctation, aortic disease).
2. Signs of organ damage:
   (a) Brain: murmurs over neck arteries, motor or sensory defects.
   (b) Retina: fundoscopic abnormalities.
   (c) Heart: location and characteristics of apical impulse, abnormal cardiac rhythms, ventricular gallop, pulmonary rales, dependent oedema.
   (d) Peripheral arteries: absence or reduction of pulses cold extremities, ischaemic skin lesions.

Guidelines for laboratory investigations

Laboratory investigations are directed at providing evidence of additional risk factors, searching for secondary hypertension and assessing absence or presence of target organ damage. The minimum laboratory investigations needed are a matter of debate. However, it is agreed that investigations should progress from the most simple to the more complicated.

Major risk factors
• Levels of systolic and diastolic BP
• Men>55 years
• Women>65 years
• Smoking
• Dyslipidaemia(total cholesterol. 6.5 mmol/l, or LDL-cholesterol. 4.0 mmol/l, or HDL-cholesterol M , 1.0,W, 1.2 mmol/l)
• Family history of premature CVD(at age , 55 years M, 65 years W)
• Abdominal obesity(circumference M>102 cm, W>88 cm)
Target organ damage (TOD)
• Left ventricular hypertrophy
• Ultrasound evidence of arterial wall thickening or atherosclerotic plaque
• Slight increase in serum creatinine (M 115-133,W 107-124 umol/l);
• Microalbuminuria(30-300mg/24h; albumin-creatinine ratio M >22, W >31 mg/g; M > 2.5,W > 3.5 mg/mmol)
Diabetes Mellitus
• Fasting plasma glucose ≥7.0 mmol/l
• Postprandial plasma glucose >11.0 mmol/l
Associated clinical conditions (ACC)
• Cerebrovascular disease: ischaemic stroke; cerebral haemorrhage; transient ischaemic attack• Heart disease: myocardial infarction; angina; coronary revascularization; congestive heart failure
• Renal disease: diabetic nephropathy; renal impairment (serum creatinine M. >133, W.124 >mol/l) proteinuria (>300 mg/24 h)
• Peripheral vascular disease• Advanced retinopathy: haemorrhages or exudates, papilloedema
M, men; W, women; LDL, low-density lipoprotein; HDL, high-density lipoprotein

Table 3: Factors influencing prognosis

1. Routine tests:
   (a) Fasting plasma glucose
   (b) Serum total cholesterol
   (c) Serum HDL-cholesterol
   (d) Fasting serum triglycerides

Risk factors and disease history	Normal BP SBP 120-129 or DBP 80-84	High Normal BP SBP 130-139 or DBP 85-89	Mild HT SBP 140-159 or DBP 90-99	Moderate HT SBP 160-179 or DBP 100-109	Severe HT SBP >180 or DBP>110
No risk factors	Average risk	Average risk	Low added risk	Moderate added risk	High added risk
1–2 risk factors ≥ 3 risk factors,	Low added risk	Low added risk	Moderate added risk	Moderate added risk	Very high added risk
TOD or DM	Moderate added risk	High added risk	High added risk	Very high added risk	Very high added risk
ACC	High added risk	Very high added risk	Very high added risk	Very high added risk	Very high added risk

ACC, associated clinical conditions; TOD, target organ damage; HT, hypertension; DM, diabetes mellitus

Table 4: Stratification of risk to quantify prognosis

(e) Serum uric acid
(f) Serum creatinine
(g) Serum potassium
(h) Haemoglobin and haematocrit
(i) Urinalysis
(j) Electrocardiogram

2. Recommended tests:
(a) Echocardiogram
(b) Carotid (and femoral) ultrasound
(c) C-reactive protein
(d) Microalbuminuria (essential in diabetics)
(e) Quantitative proteinuria (if dipstick positive)
(f) Fundoscopy (in severe hypertension)

Step 3: Classification and Stratification

The relationship between BP levels and risk of end organ damage is continuous and this makes any numerical definition and classification of hypertension arbitrary. The real threshold for treating hypertension must be a flexible one resulting from evidence of cardiovascular risk profile of each individual. The new guidelines introduced a new classification that includes high normal BP (ESH [3]) or prehypertension (JNC 7 [2]).

This new designation is intended to identify those individuals who would benefit from preventive measures such as lifestyle change or early intervention.

On these bases, a classification using stratification for total cardiovascular risk (Table 4) was suggested in the WHO/ISH[4] and ESH/ESC[3] guidelines. The terms low, moderate, high and very high added risk are calibrated to indicate an approximate absolute 10-year risk of cardiovascular disease of,15%, 15–20%, 20–30% and >30%, respectively, according to Framingham criteria [15], or an approximate absolute risk of fatal cardiovascular disease<4%, 4–5%, 5–8%, and >8% according to the SCORE chart [16].

Step 4: Therapeutic Strategy

Primary prevention and Lifestyle changes

Primary prevention entails that all patients should be screened for HBP and increased cardiovascular risk. Whereas, patients with increased risk or on treatment should be encouraged to attend for regular check-ups, the worried well should be reassured and discouraged from doing frequent BP check-ups (Box 1). On the other hand, clinicians should take every opportunity not to miss those patients who attend clinic infrequently and are not aware of their BP and cardiovascular status.

Adopting a healthy lifestyle by all persons is critical for the prevention of HBP and is an indispensable part in the management of hypertension. Each encounter for BP check-up should be an opportunity to advise patients on healthy lifestyle. Lifestyle advice is appropriated for all patients with or without HBP or on antihypertensive therapy. The lifestyle measures that are widely agreed to lower BP and cardiovascular risk are indicated in Table 5.

Secondary prevention and medical intervention

Guidelines for initiating antihypertensive treatment are based on two criteria: the level of SBP and DBP (Tables 1 and 2) and the total level of cardiovascular risk (Table 4). The total level of cardiovascular risk has become a more important indicator than

Lifestyle change	Reduction in SBP	Other benefits
Smoking cessation	Not quantified	The single most powerful lifestyle measure for the prevention of non-cardiovascular and cardiovascular diseases
Weight reduction	5-20mmHg/10kg	Improve associated risk factors such as insulin resistance, diabetes, hyperlipidaemia and left ventricular hypertrophy
Regular physical activity	4–9 mmHg	Same as above
Healthy eating plan	8-14mmHg	Same as above
Moderation of alcohol intake	2–4 mmHg	Associated with a high risk of stroke particularly so for binge drinking
Reduction of dietary salt	2–8 mmHg	

Table 5 - Lifestyle modification and reduction in BP

(Adapted from ESH/ESC guidlines)

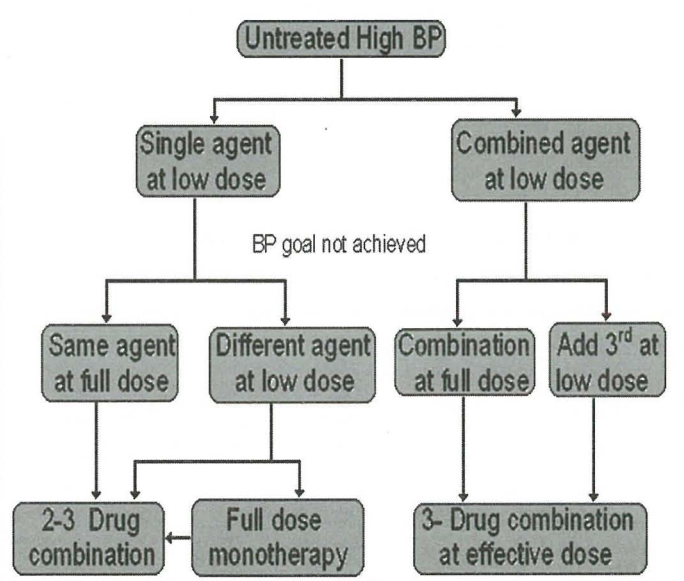
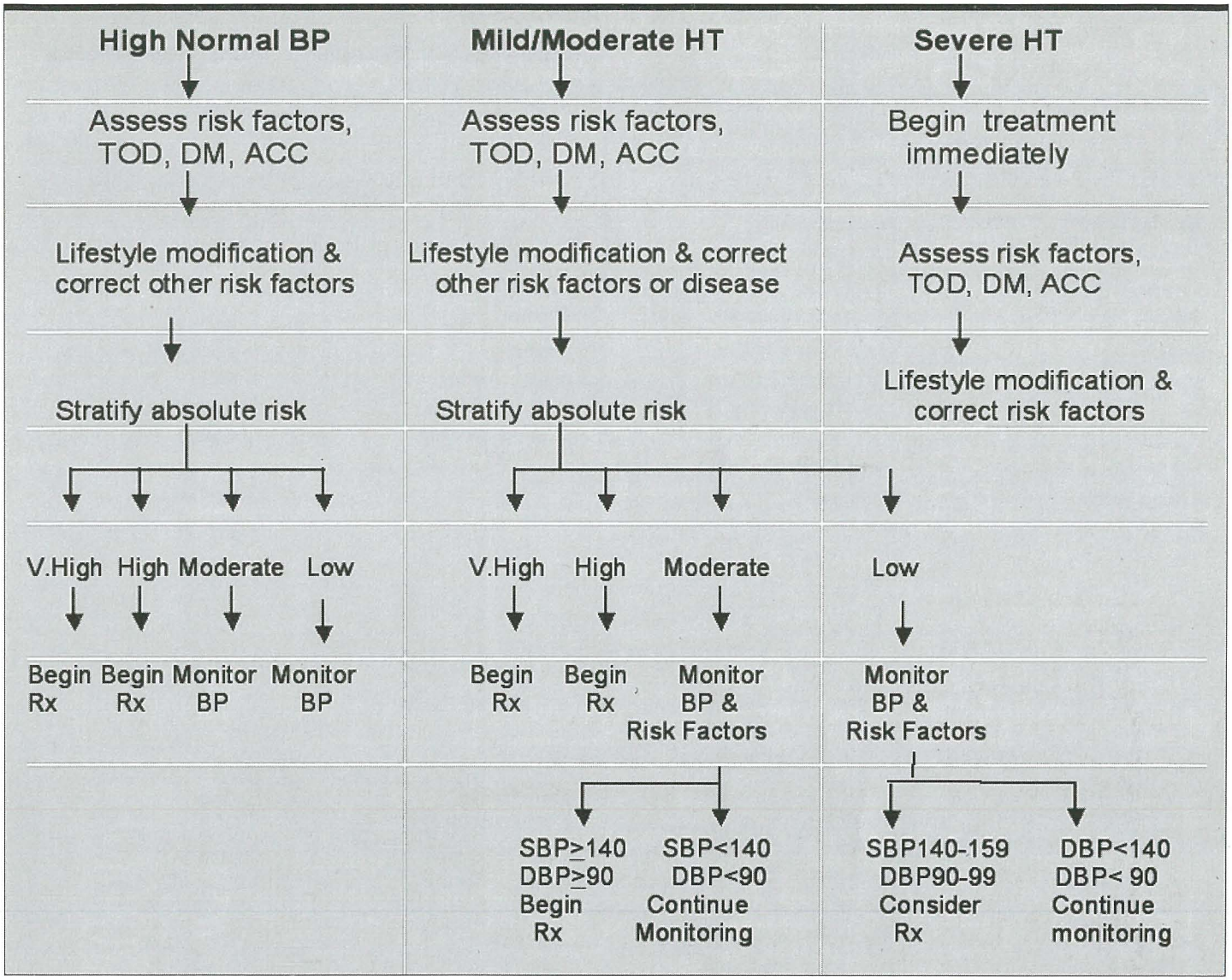


Figure 1: Monotherapy or combination therapy

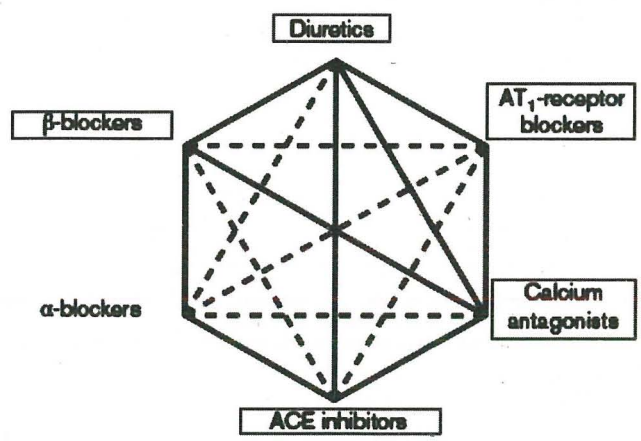


Box 2: Recommended Therapeutic Strategy

the BP level for intervention. Box 2 includes recommendations about initiation of treatment in patients with all grades of hypertension.

The evidence of BP lowering benefits in patients with high normal BP is so far limited to subjects with stroke, coronary artery disease and diabetes. Antihypertensive treatment within high normal BP range can only be recommended for patients who are at least at high risk. Close monitoring of BP is recommended for patients at low or moderate risk, who are considered to benefit mostly from lifestyle modification measures and correction of other risk factors.

In patients with mild to moderate hypertension, it is recommended to check BP values on several occasions, initiate lifestyle measures and stratify absolute risk. Antihypertensive drug treatment should be initiated promptly in subjects classified as at high or very high risk, whereas in subjects at moderate or low added risk BP, as well as other cardiovascular risk factors, should be monitored for extended periods (at least 3 months) with only non-pharmacological treatment. If after extended observation,



Possible combination of different classes of antihypertensive agents. The most rational combinations are represented as thick lines. ACE, angiotensin-converting enzyme. The frames indicate classes of antihypertensive agents proven to be beneficial in controlled intervensional trials.

Figure 2: Drug Combinations (Adapted from ESH/ESC guidlines)

Class	Indications	Compelling Contraindications	Possible Contraindications
Diuretics (thiazides)	Congestive heart failure; elderly hypertensives; isolated systolic hypertension; hypertensives of African origin	Gout	Pregnancy
Diuretics (loop)	Renal insufficiency; congestive heart failure		
Diuretics (anti-aldosterone)	Congestive heart failure; post-myocardial infarction	Renal failure; hyperkalaemia	
Beta-Blockers	Angina pectoris; post-myocardial infarction; congestive heart failure (up-titration); pregnancy; tachyarrhythmias	Asthma; chronic obstructive pulmonary disease; A-V block grade 2 or 3	Peripheral vascular disease; glucose intolerance; athletes and physically active patients
Calcium antagonists (dihydropyridines)	Elderly patients; isolated systolic hypertension; angina pectoris; peripheral vascular disease; carotid atherosclerosis; pregnancy		Tachyarrhythmias; congestive heart failure
Calcium antagonists (verapamil, diltiazem)	Angina pectoris; carotid atherosclerosis; supraventricular tachycardia	A-V block grade 2 or 3; congestive heart failure	
Angiotensin-converting enzyme (ACE) inhibitors	Congestive heart failure; LV dysfunction; post-myocardial infarction; non-diabetic nephropathy; type 1 diabetic nephropathy; proteinuria	Pregnancy; hyperkalaemia; bilateral renal artery stenosis	
Angiotensin II receptorantagonists (AT1-blockers)	Type 2 diabetic nephropathy; diabetic microalbuminuria; proteinuria; left ventricular hypertrophy; ACE-inhibitor cough	Pregnancy; hyperkalaemia; bilateral renal artery stenosis	
Alpha-Blockers	Prostatic hyperplasia (BPH); hyperlipidaemia	Orthostatic hypotension	Congestive heart failure

Table 6: Indications and contraindications for the major classes of antihypertensive drugs

systolic values >140 or diastolic values > 90 mmHg persist, antihypertensive drug treatment should be initiated in patients with moderate risk, and considered in patients with lower risk.

In patients with severe hypertension, the elevated BP values should be checked within a few days and treatment instituted quickly, without the preliminary need of establishing the absolute risk. Complete assessment of other risk factors, target organ damage, or associated disease can be carried out after treatment has been started, and lifestyle measures can be recommended at the same time as initiation of drug therapy.

Step 5: Choice of antihypertensive drugs

The main benefits of antihypertensive therapy are due to lowering of blood pressure per se and all the standard major classes of antihypertensive agents (fig 2) are equally suitable for first-line therapy as monotherapy or combination therapy, provided that there are no associated complications. There is also evidence that specific drug classes may differ in some effect, or in special groups of patients. When there is evidence of increased cardiovascular risk profile, target organ damage, clinical cardiovascular or renal disease or diabetes then, specific antihypertensive drugs with compelling indications (based on clinical trial) should be used (Table 6). Long-acting drugs or preparations providing 24-h efficacy on a once daily basis are generally preferred as they offer better BP control.

Within the array of available evidence, the choice of drugs will be influenced by many factors, including:

- previous experience of the patient with the agents;

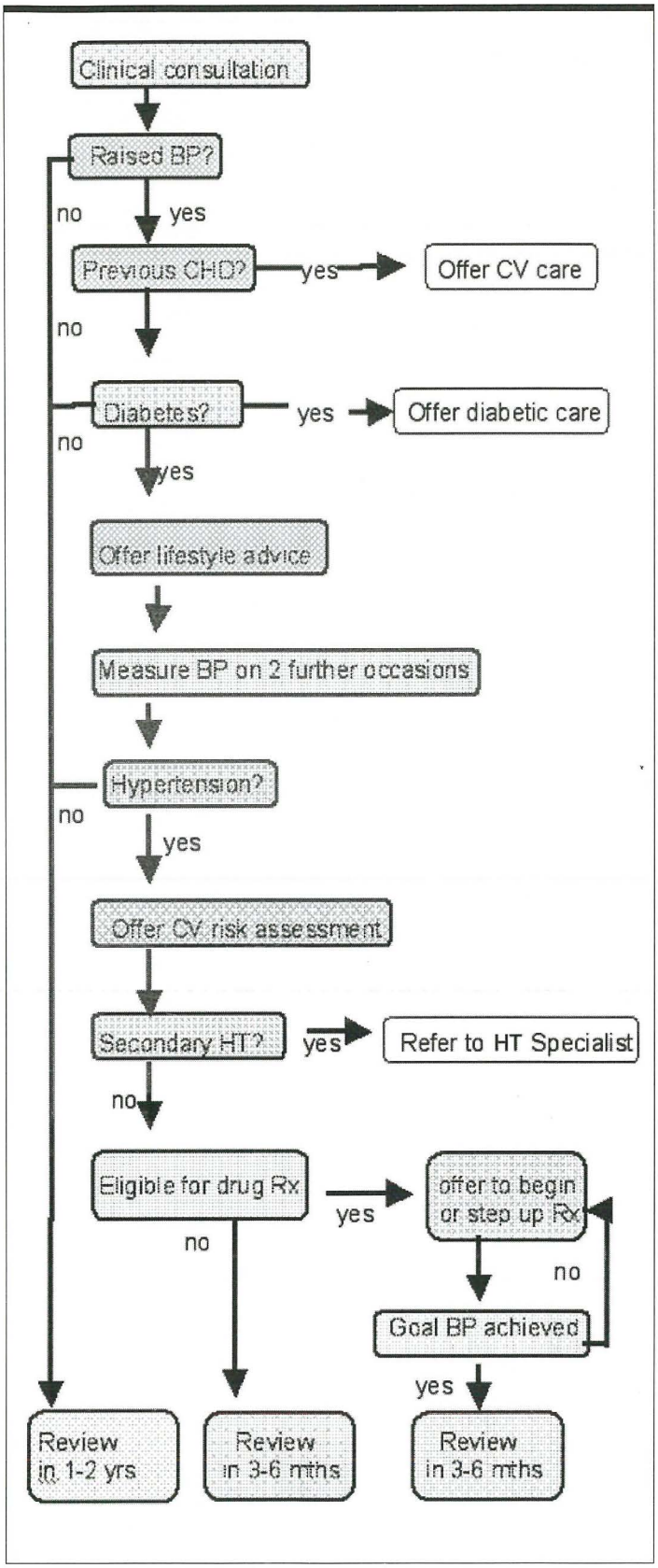


Figure 3: Management flow chart
(Adapted from North of England hypertention guidelines development group)

- cost of drugs;
- patient's preference;
- clinical indications

Monotherapy versus combination therapy

In most, if not all, hypertensive patients, therapy should be started gradually, and target BP values achieved progressively through several weeks. To reach target BP, it is likely that a large proportion of patients will require combination therapy with 2 or 3 agents. In mild hypertensives, monotherapy is likely to be successful more frequently. On the other hand, patients with moderate to severe hypertension or with concomitant disease, such as diabetes, are more likely to be controlled with combination therapy. According to the baseline BP and the presence or absence of complications, it appears reasonable to initiate therapy either with a low dose of a single agent or with a low-dose combination of two agents (figure 1). The advantage of starting with low dose monotherapy, is the ease to identify adverse effects and to find the drug to which any individual patient best responds. But the procedure is laborious and frustrating for both doctors and patients, and may lead to low compliance. An obvious disadvantage of initiating with two drugs is that of potentially exposing the patient to an unnecessary agent, but the advantages are that:

1. by using two drugs with different mechanisms of action, it is more likely that blood pressure and its complications are controlled;
2. by using combinations, both the first and second drugs can be given in the low dose range that is more likely to be free of side-effects;
3. fixed low-dose combinations allowing the administration of two agents within a single tablet, thus optimizing compliance.

Figure 2 shows the most commonly used drug combinations that were proved to be effective and tolerated by patients

Conclusion

It is now recognised that the management of hypertension must not be performed in isolation (Box 2, Fig 3). Full cardiovascular risk assessment of the patient is required. The patient should be considered holistically and all risk factors and associated clinical conditions must be assessed and managed. Despite major efforts to diagnose and to treat hypertension, this condition remains a leading cause of morbidity and mortality, and goal BP levels are seldom achieved. It is therefore highly desirable to improve this unsatisfactory delivery of care of such a common condition.

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Man in antiquity and much later time capsules

Dr Charles J BOFFA

The Maltese Islands have sustained a stream of human life since the very early people, probably from Sicily first settled here around 5500 B.C., and gradually developed mostly in fertile areas where water was available . The first settlers were agriculturists. Looking back, one can realize that their survival depended mainly on a widening of their understanding of nature and a deepening of their knowledge on how to handle and use what nature provided. Aside this, they tried to safeguard themselves as much as possible against disease, accidents and catastrophe.

They grew barley, lentils and in due course wheat and ground part of their meals in stone mortars and querns. They kept herds of goats, sheep and perhaps fenced their land. In due course the fig and olive trees were cultivated. The sea trade which gradually developed in Phoenician times in countries bordering the Mediterranean and in later centuries other traders must have affected the Maltese set-up and the introduction of new skills.

As time went on, Malta and Gozo had contact with other civilizations. The tools in Maltese prehistory were made out of a) Chert - a form of quartz available locally, b) Bones, c) Obsidian - a sort of volcanic glass imported from Lipari and Pantelleria, d) Flint - Imported. This was fairly easy to work and could be given a sharp edge. A pebble or bone hammer was used to strike long flakes of flint from the main stone. Axes with flint blades were also made.

The local inhabitants could have acquired knowledge from other countries regarding some uses of plants and herbs which grew in other Mediterranean lands. Our forebears continued to use them, especially when they realized that these grew in our Islands. This far back in the past, we can only wonder about the contemporary uses and our conclusions have to be somewhat speculative. In the era A.D. and over the centuries that followed, it is likely that more and more plants and herbs were utilized with a view to help them in health and disease.

It is impossible to describe clear visions that reflect conditions that came to pass in prehistoric times regarding Man's attempts to lessen pain and the practice of some form of crude surgery. Man is distinguished from animals, among other attributes by his ability to make and improve tools of various shapes and sizes and to communicate ideas. Considered functionally, tools are utilized in what may be described as extensions of the forelimb - indeed a wonderful multipurpose vital part of our anatomy.

Human skulls unearthed in some countries show that trepanation, as described in my paper published in the Family Physician, no., 24, Dec 03, was carried out in prehistoric times. Sharpened flints were probably used to perform trepanation, before the discovery of bronze and iron. Flint was imported from Sicily, such as from Monte Ibles. It is surmised that probably it was also used to open abscesses and let out pus and blood and to remove a superficial growth on the skin. Teeth of fish were possibly also used for this purpose.

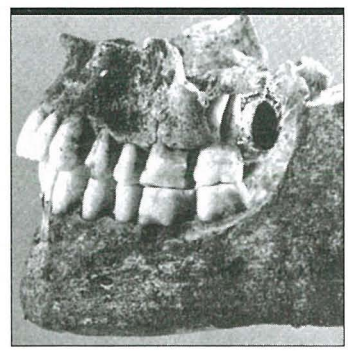
As learning in the use of tools increased, saws for use in amputations were made from flints and bronze. This is known because certain mummies, (not in Malta) indicate such operations. In due course with the introduction of bronze and iron, suitable knives, daggers, saws, scissors, forceps and needles came into use. The relics found at Pompei included some strange looking, but interesting surgical instruments.

It is believed that sewing with a waxed thread, besides other material, of a bad cut or wound was an already established procedure in Roman times, possibly earlier.

Because dietary habits influence many aspects of lifestyle, theories based on dietary models have been important in the study of human development. Comparative anatomy does help in understanding certain features including tooth wear, but allows only the most specialized diets to be ruled out. A biomechanical analysis shows that jaw tooth forms are rather subtle. Major dietary types can generally be distinguished by their microwear.

Within limits, we can comment about the diet of early Man in our Islands. This probably included a considerable amount of rather hard food, besides edible plants, seashells and pods - which consisted of small seeds with fairly hard protective cases. Since the biting forces of the mandible and muscles of mastication are used to generate pressures over occlusal surfaces, gradual abrasion resulted in attrition. The pressures which are applied vary between individuals, as the size of the jaws and the related strength is linked with the biomechanics of human chewing. The hardest tissue in the body is tooth enamel which can withstand pressures.

The left side of the jaws of a child of about 4 years, showing extensive buccal caries in the upper deciduous molars and caries free lower deciduous molars



The jaws and teeth of an adult, probably just past middle age which show some attrition on the molars

However these pressures over the years, affect toothwear and over a very long period of years can also affect the temporo-mandibular joint, and can withstand some adaptation to a changing mastication pattern. This is another aspect outside the confines of this paper.

And now some reference to cutting or pointed tools. It is likely that the first razors were of obsidian or flint. Bones, sometimes including bird bones, were used for making points. Perforated needles of bone were also found at the Tarxien temples, both straight and curved. Often the teeth from ancient skulls unearthed from graves and elsewhere are found to be in a ground-down condition. The rate of attrition is influenced by the diet, occlusion and the way a person bites. A coarse diet brings about more attrition. Another minor factor which may be suggested is that the grit which forms in limestone and pottery querns where food is mixed, affected the enamel of the teeth. Neolithic folk and later communities utilized hollowed stones for milling. The friction generated with a pestle in a mortar resulted in the formation of some grit; that is countless minute particles of stone became incorporated with the milled mixture.

With the end of the Middle Ages a gradual development began, characterized by new concepts and analysis of the work of Greek and Roman medical practice and related matters. This was the beginning of the so-called Humanism, within the wider framework of what is referred to as Renaissance.

It is not easy to assess the standard of medicine and surgery of those times, but the death mortality was very high. The avant garde reasoning of the eminent physician Paracelsus of the first half of the 16th century is noteworthy. He recorded (liberal translation): "Medicine is not merely a science and an art. It does not consist only in compounding pills and plasters and drugs of all kinds, but deals with the human processes of life which must be understood before they can be aided and guided".

In the following century another important consideration was addressed in various teaching medical centers. Human dissection - a vital part in a medical curriculum became obligatory and gave students the chance to broaden their knowledge and understand better in a practical way, the human body, its insights and functions.

As the knights of St. John gradually established their presence in Malta and Gozo, more fields and areas not far from the coastline were brought under cultivation. Life in general improved with a more safe and stable existence. In the early days of the Knights, much of the medical and surgical procedures were in general still based on the Greek physician Hippocrates, the Roman Galen and the Avicenna principles. The wise Hippocrates, among his various writings noted (liberal translation): "Prayer indeed is good, but while calling on the gods, a man should himself lend a hand". Hippocrates also advocated the importance of varied nutrition and exercises. The Roman physician Claudius Galen (131-201 A.D.) was instrumental in creating a system of therapy that influenced European practice for the next century and a half.

And now to a much later time horizon. The Salerno School in the Kingdom of Naples was in 1224, Europe's first officially recognized medical school. Its training of medical students, which for the first time ever included some female students, contributed to improvements in medicine and surgery.

The topic of the significance of urine is very useful to study the interaction of causes and effects. Circa 1450, the importance of the examination of urine was realized further and charts were made to help doctors make a diagnosis, within limits, with information on what colour, odour and consistency implied. Over the years, these charts were gradually improved and remained a diagnostic aid for centuries.

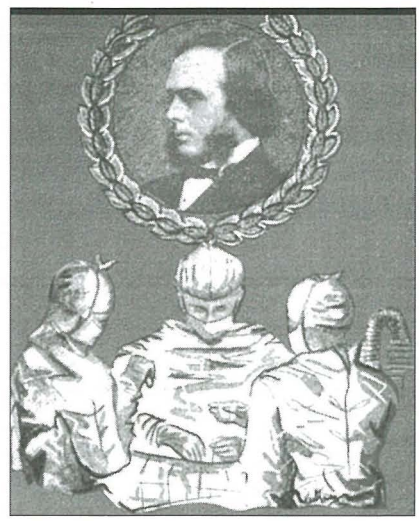
At this point I may well mention Healing of Wounds. There is a manifest inequity between the treatment of wounds in the medieval times and the present. Healing is a delicate process which triggers the body to start an anabolic process in its metabolism. In a fairly healthy person there are three main phases: first inflammation, secondly the hyperplastic phase and lastly the gradual remodeling of the scar. The depth of the wound, the growth of new tissue and the microenvironment are important factors involved in healing.

One of the avant-garde doctors (outside Malta) was the Frenchman Ambrosio Pare (b.1510, d.1590). He campaigned against some incredible practices which did not make sense,

such as the medieval custom of placing hot irons on a wound to stop bleeding and sometimes treating gunshot wounds with boiling oil which did more harm than good. These procedures brought about serious complications such as burns, interference with blood supply, destruction of tissues and sometimes the loss of a limb. How long boiling oil and cauterization remained in use in Malta is not clear. However it is known that some physicians and barber surgeons were against it and it had already been discontinued by the early 17th century, perhaps earlier. Besides these horrors, diseases and poverty; the population suffered immensely at times of pestilence, sadness heaped upon sadness as widespread deaths ravaged their lives.

And now some focus on the Knights Hospitallers. The Sacra Infermeria was under the control of the Knights with medical, surgical and nursing staff. The impressive great ward, which runs almost parallel with the Grand Harbour is 502 feet in length and 34.5 feet wide. The novices of the order also attended to the needs of the sick and infirm - irrespective whether they were Maltese or slaves. Each Langue was in duty bound to serve one day every week; the Grand Master also attended on Fridays - indeed a laudable gesture. The service rendered was of a high standard and attention was given to adequate cleanliness, a good diet and regular daily care. Although the mortality rate was high, many operations carried out had a positive outcome. All instruments were boiled, so a form of sterilization was practised. It is surmised that at a period in time, patients with certain wounds, while recuperating were occasionally given the opportunity to wash them in clean seawater (saline), which in moderation was beneficial, especially in summer.

The average age of death used to be much lower than it is now. "To every man upon this earth, Death cometh sooner or later". The coming of death must have been in many cases even harder to bear then than now and physically painful as well, because soothing drugs were not available. Old age must have been a difficult time. The shortsighted had no proper spectacles. The deaf had no aids except ear trumpets. The toothless lacked dentures. Lepers were ostrasized from society, even those who developed skin disease, or thick scales and sores.



Dr Joseph Lister used carbolic acid as an antiseptic in an effort to reduce hazards in surgery

The extraction of carious teeth was generally very painful and dreadful. Events continued to unfold with more developments, among others the use of anaesthetic.

An important breakthrough took place in 1846, when ether was used at the Massachusetts General Hospital. Ether was the first anaesthetic. Various types of surgical interventions became possible. Yet the success rate remained unsatisfactory, mainly because germs from the air and the operating theatre infected open wounds. The infections often ended in death. Around 1865, an English surgeon - Joseph Lister used carbolic acid with a view to control the germs threat. This was not a satisfactory method and it took many years later for all round effective sterilisation to evolve.

This brings me to what to some extent, I may refer to as the end of an era and the beginning of a new chapter in the ascent of the long road of medicine, surgery and dentistry for the good of humanity.

An old type tongs used for removing foreign bodies, such as bullets or splinters, typical of the Knights' period

The uses of plants and herbs in medicine

Dr Charles J BOFFA

Various plants have been used thousands of years ago, in efforts to cure certain ailments in Mediterranean countries and elsewhere. As early as around the 4th and 5th century in Greece, Hippocrates was recommending asparagus and garlic for their diuretic and health aid qualities, willow leaves to relieve pain and headaches, poppies to help insomnia. In fact one of the ingredients of aspirin comes from the willow tree and some of the drugs used to treat certain heart problems come from the foxglove. Likewise in Sicily, Italy, France, Greece and Egypt, extensive use of certain plants were utilized in antiquity with a view to cure or allay diseases.

The use of certain plants and herbs, has a long tradition in our islands, even to a limited extent up to as recently as the 1800's and very early 1900's. Mr Carmelo Penza, botanist and curator of the herbatorium at the Argotti Gardens, used to explain to us who attended the course for the B.Pharm, between 1948 and 1952, the uses of local wild and cultivated plants in past times, etc.

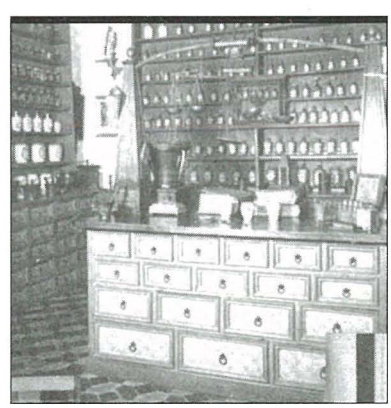
The various plants and brief notes by no means complete, which I am mentioning later, provide an insight into their medical and health uses and which were considered of value in varying degrees. I have paraphrased parts of the text because limits of space have necessitated condensation. Within limits several were useful for some conditions, but many had little if any positive effects and were based mainly on ancient thought or folkore. It must be borne in mind that the wide spectrum of modern medicines we are now familiar with, were non existent.

I am not in any way advocating or recommending their use. Furthermore one should not meddle with herbal medicine. Their use have receded in the mists of time, yet they offer interesting historical facets. The use of several of them leave various questions unanswered. Between the 16th and 18th centuries, various plants continued to be used and afforded promise, hope and pitfalls. The physicians, surgeons and staff at the Sacra Infermeria in Valletta and other hospitals, during the Knights of St. John Hospitallers, attached a lot of importance to the care of patients irrespective of creed - Maltese, slaves and foreigners. A considerable number of medical preparations were based on local herbs and they set up an extensive garden in which a number of plants that were needed were cultivated. Some medicines were imported from Sicily. Private doctors also prescribed a variety of herbs. Several plant based preparations, continued to be used after the Knights left Malta, but gradually over the years these decreased with the introduction of scientifically based ones.

"He causeth the grass to grow for the cattle and herbs for the service of humanity". Psalm, 104:14

The word 'Pharmacy' is derived from the Greek word 'Pharmakom' meaning remedy. In general it may be said that many things in life were not perfect. Some aspects of very early medicine may be considered strange but well intentioned. Customs, knowledge and perspectives were transmitted by elders to their young ones, as they faced the stark realities of life and disease. Since ancient times life had a precious meaning. Furthermore certain customs grew out of something innate in life which caused early Man to seek help from plants. The fact that household pets in our times instinctively eat certain types of grass when in physical distress and are sometimes somewhat relieved, is indeed significant. While many of the plant concoctions and some other substances in ancient times were probably therapeutically inert - that is without any active chemical or beneficial properties, at least several were of pharmacological or positive value healthwise. Some are still in use today, such as opium, acacia, camomile, sodium bicarbonate, etc.

At a professional conference which had been held in Athens, in 1968 Dr Paul Ghalioungui had referred to an ancient papyri which briefly indicates that the Egyptian physicians at times



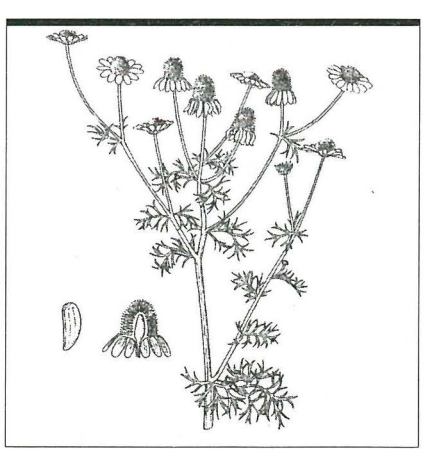
A typical pharmacy of past times with many drawers, bottles and utensils where prescriptions were prepared (via G. Agius)

treated wounds with a certain type of fungus - like mould plant. Although this is subject to conjecture, he asked, "Is it possible that this acted in some way, as penicillin does in our times? But this was far back in the past to the years around 2000 B.C. Not likely, but this gives food for some thought and one cannot exclude this remote possibility. The Greek philosopher Saphocles (495 - 406 B.C.) noted " Marvels are many but Man is the greatest" (liberal translation).

It may be said that in general, life is uncertain even under good conditions. The widespread belief in past centuries in the remedial qualities of various plants is indeed interesting. They offered a source of hope to a wide spectrum of people. Analysis of the time series in which they were utilized is not at all easy, because a number of them remained in use up to the 19th century or so, while others fell in disuse. Some of these parameters, for want of a better word, are well defined. One of these is **Camomile** (Kamumella). This plant which grows wild holds some fascination and has been in use since ancient times. It has tiny pretty white flowers and has a pleasant characteristic smell. In the past and until a few decades ago, including the period of the Second World War, this was collected, dried and used by families, the same way a cup of tea is brewed sometimes as a drink during daytime (when tea became rather scarce) and also before sleeping especially by tense people.

Independently of the WWII period, it was also used for tummy ache and indigestion in past times. Camomile has a mild tranquillising effect. At present it is still sometimes utilized and even marketed in some countries. In fairly recent times, a liquid camomile extract with additives was introduced in the pharmaceutical field - claimed as a relief to some extent, in minor aphthous stomatitis of the mouth. It is claimed that it has an element of anti-inflammatory, antiseptic properties and also some anti-bacterial effect against some gram-positive bacteria, bacteriodes gingivalis and anaerobes.

The spiny Chicory (Ċikwejra) is a rather small spherical plant with hard spinelike branches and sometimes referred to as 'qanfuda', because its spikes somewhat resemble those of a hedgehog. Between May and July it forms attractive blue flowers



A flowering plant of Camomile - Matricaria Chamomilla L.

a little less than two centimeters in diameter. Its leaves were used over past centuries to help urination and in diabetes.

The Chicory, as distinct from the spiny one was more popular. It was considered a good tonic, helped the liver to function and the digestive tract and also used for patients suffering from gout. Strangely enough on rare occasions some mashed chicory was spread over pimples and bruises.

Gout effects mostly males and is not a single disease. It seems that it effected some Knights and mostly others on a rich diet. A mixture of cinnamon, nutmeg, ginger, cloves and sometimes honey was prescribed with a view to alley pain from gout and also colic. Primary gout, an inborn error of uric metabolism is characterized by hyperuricemia and recurrent attacks of acute arthritis, most often of the great toe and eventually by tophaceous deposit of urates. There is also secondary gout.

Castor oil (Żejt tar-Rieġnu), with its bad taste and very dangerous to life was used in small doses in the past as a purgative. This was obtained from the castor beans of the plant Ricinus Comunis. It is likely that it was introduced in Malta in past times, probably from Africa. Although the toxicity of Castor beans has long been known, the actual strong poison was only discovered in the 1880's. Suffice to say that in certain doses, it is almost twice as poisonous as cobra venom. Ricin is very potent because it is neurotoxic, cardiotoxic and hepatotoxic. Ricin halts protein synthesis and induces cellular death. When used as a purgative, it was given in rather small doses, yet it is very dangerous to human and animal life. Castor oil acts as a purgative after hydrolysis in the small intestine where the irritant ricinoleic acid is formed. The liquid contents of the small intestine pass rapidly onwards, resulting in a soft or fluid stool after about 2 to 4 hours. In early 1900's and later, medical practitioners in private practice and in hospitals were informed of the dangers of castor oil and advised not to prescribe it.

Cascara, together with senna, rhubarb and aloes are derived from plant extracts, and are classified in the anthraquinon group. Cascara which was obtained mostly from the Californian buckthorn was fairly popular as a purgative. Its mode of action is not fully clear, but in my time, it was believed that it stimulates Aurbach's Plexus in the large intestine and so provide physiological purgation.

Garlic (tewm) merits special mention. It was considered beneficial for patients with high blood pressure (and still is) although its dynamics were still unclear. Garlic is believed to protect to some extent against CHD. Researchers in the USA in the early 1980's (and around 1986 in Italy) had analysed five placebo controlled studies involving 400 people with high cholesterol levels. They found that a daily intake of as little as one-half to one clove of garlic consistently, reduces cholesterol by about 9%. (Medicine Digest, July/August 1994).

The late Giuseppe Agius, Ph.C. - a very competent and humane pharmacist who qualified in 1922 and served throughout his working life in his pharmacy in Paola gave me a lot of

information about local herbs, which I acknowledge with thanks. Until around the mid thirties, farmers used to supply him with some plants and herbs which he and some local doctors sometimes utilized for patients. This went on also at times during the Second World War when stocks of various pharmaceutical items became scarce or ran out, and a few plants came in useful.

The following were used fairly extensively in past centuries.

Squill (Għansar). Two varieties - red and white were sometimes used for certain cardiac conditions, perhaps because they contain Ilycosides.

Onions (Basal) were used as a diuretic and also (but probably did not) to eliminate intestinal worms, including the dreaded tapeworm.

During late 1941 and 1942, when cases of subclinical scurvy appeared in Cottonera and Valletta, **Carrots** (zunnarija) were recommended because they contain Vitamins A, B and C, mixed with honey. Carrots were also recommended, together with apples for laryngitis and cough. Because of unsatisfactory nutrition, pilots were offered some shredded carrots with their breakfast.

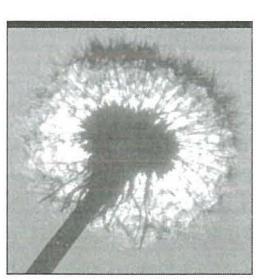
Vitamins C, E, selenium and betacarotene help to strenghten the body when frequent stress effects it negatively.

The use of certain herbs/plants was indeed strange. For example, decoctions of the horsetail plant and of the wall-pellitory were sometimes utilized among adults for the relief of difficult micturition. For diuresis and the expulsion of urinary particles and aiding stones to be eliminated.

Another peculiar use was that of the **Hêlebore species,** which included the Christmas rose. This was supposed to partly alleviate madness or mental strain!

A decoction of **mashed apples** was administered 3 times a day for tonsillitis and ulcers.

Lentisk, Pistacia lentiscus (Deru). This shrub which has a special odour produces small red berries. In some Mediterranean islands, in the past, a type of oil was extracted from berries and sometimes used in oil lamps. Its resin was chewed, because it was thought that somehow it neutralized bad breath and helped in oral hygiene. Although it seems that Lentisk was somewhat used as such, I think that it was not popular and very limited in use. However, it is surmised that at one time, it was sometimes used by members of the crew of galleys of the Knights.



Many Plants were utilised in medicinal preparations and as health aids

Malva sylvestris (Ħubbejża)was used as a gargle for inflamed gums and mouth ulcers; also given to children during painful tooth eruption.

Common Mallow (rich in mucilage) was believed to be useful in helping to eliminate to some extent catarrh in the bronchi and act in a way as a mild antihistamine is used today.

White Migonette (Demb il-Ħaruf): Its roots were boiled and the extract used as a gargle for inflamed gums. At times used as a mild laxative.

Opium Poppy (Ix-Xaħxieħ): As a sedative, a mild pain reliever in headaches due to fever, carious teeth or growing children. It was generally administered as a tincture made with wine or honey. Headache was supposed to be relieved by smelling rose-petals steeped in vinegar or by placing slices of raw potato over the forehead and keeping them in place by a bandage!

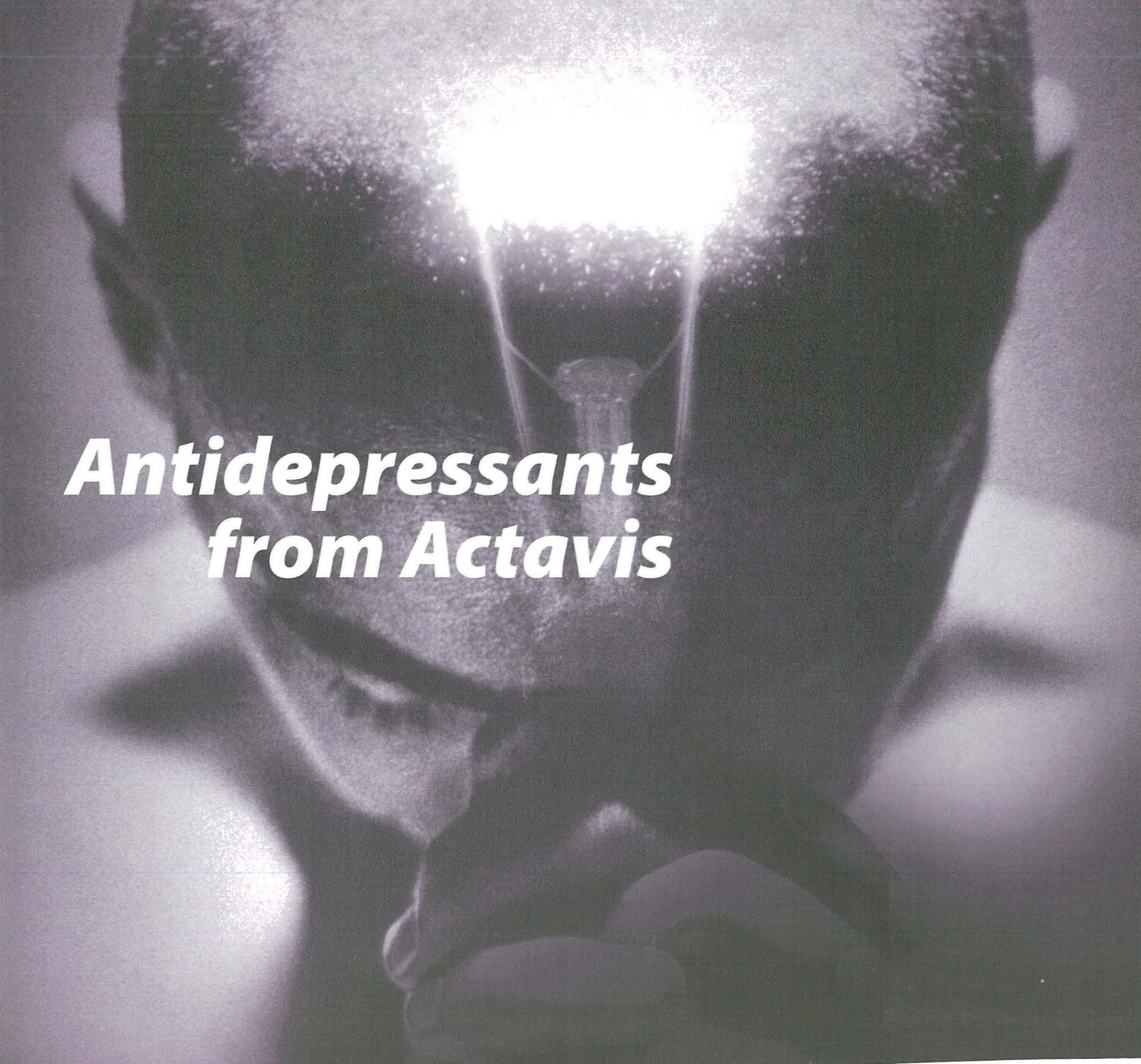
Walnuts (Ġewż): In late medieval times and later years, walnuts were considered of value health wise and in moderation of benefit to the heart, to boost the intellect and stabilize emotions. Fairly recent research indicates that omega-3 polyunsaturated fatty acids, like those found in walnuts can have a positive effect (in persons of normal weight) on certain heart health risk factors, such as LDL or high cholesterol, inflammation and perhaps to a limited extent even diabetes. (Wollongong Univ. Australia).

Pennyroyal (Plejju): It has nice flowers. This plant seems to keep away mosquitoes to some extent and was used for this purpose. It was also boiled and drunk to relieve stomach discomfort and considered of benefit during colds. In recent times, some manufacturers incorporated it in certain toothpastes.

And now a reference to the once known as **Żerriegħa l-Briegħed** which at some point in time were used with a view to thwart off fleas and lice. The institution previously known as the Asylum for the Aged and Incurables or Poor House (now the Residence for the Elderly) was opened in 1892. In early 1900, with a view to control these pests, a quantity of these seeds was ordered for its use at the Poor House. I cannot say what effect these seeds had. Obviously at that time, DDT and the insecticides in use today were not available.

Coral weed- Corallina elongata (Korallina) which grows profusely on rocks near the surface and is common along some Maltese shores also deserves mention, although its effectiveness is subject to conjecture. This weed and a few other red algae were in the past, before the introduction of effective medicines, collected, dried and used as remedy, sometimes in conjunction with raw unions, for the treatment of intestinal worms, including tapeworm which brought so much anguish and discomfort and were difficult to eradicate.

Barley (Xgħir) was used in a variety of conditions such as a food supplement-nutrient and was believed to calm nerves. It contains minute amounts of Vit E, phosphorus, calcium and iodine. Given to patients suffering from anaemias, bronchial catarrh, enteritis, dyspepsia, dysentery and cystitis. Also used as a poultice (ġbara).



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The dose may be increased, if required, up to 40 mg per day. *Children:* Paxetin is not recommended for individuals under 18 years of age. *Impaired renal and/or hepatic function:* Paxetin should be used with caution in patients with impaired renal or hepatic function. The maximum dose is 40 mg per day. **Contra-indications:** Paxetin is not intended for patients who are hypersensitive to the drug or to any of its excipients. Paxetin should not be used concurrently with MAO inhibitors, and not within two weeks from the time, treatment with MAO inhibitors was discontinued. Subsequently, treatment with Paxetin should be started with caution, and the doses should be raised progressively until maximum response is achieved. Treatment with MAO inhibitors should not be initiated within two weeks from the time treatment with Paxetin has been discontinued. **Special warnings and special precautions for use:** Patients considered to be at risk of suicide should be kept under close observation during the entire time of treatment. It is recommended that caution should be observed in patients who have previously had convulsions and been subject to mania. Patients who have recently suffered from myocardial infarct or heart disease should be kept under appropriate observation. **Interaction with other medicaments and other forms of interaction:** As is the case with other serotonin reuptake inhibitors, paroxetine inhibits the specific hepatic enzyme cytochrome P450 isoenzyme (2D6). Drugs that are metabolised by cytochrome P450 (2D6) include specific tricyclic antidepressants (e.g. nortryptiline, amitryptiline, imipramine and dexipramine), specific serotonin reuptake inhibitors (e.g. fluoxetine), sedative phenothiazine drugs (e.g. perphenazine and thioridazine) and drugs for arrhythmia (e.g. propaphenone and flecainide). Caution should be observed with the administration of Paxetin concurrently with sedatives (neuroleptics) and oral anticoagulants. Drugs that inhibit (e.g. cimetidine) or activate (e.g. phenytoin) microsomal enzymes that are necessary for the metabolism of paroxetine can affect its metabolism and pharmacokinetic properties. The adaptation of doses at the start of the treatment is not considered necessary when the drug is to be administered together with a drug that activates enzymes necessary for the metabolism of drugs. If doses are adapted later, this should be done on the basis of the clinical effects. Patients should be advised to avoid taking alcohol during Paxetin treatment. The use of Paxetin together with tryptophan is not recommended as it can lead to side effects, mainly headache, nausea, increased perspiration and dizziness. The use of paroxetine together with anticonvulsive drugs (e.g. phenobarbitol) can lead to an increased frequency of side effects. Paroxetine can interact with drugs that are mostly bound to plasma proteins thus leading to increased side effects. Utmost caution should be observed when administering Paxetin together with lithium as the experience with such patients is limited. Following repeated doses, a study of the interaction between paroxetine and diazepam showed no changes in the pharmacokinetic properties of paroxetine which would recommend changes in the dosage for patients taking both drugs. **Pregnancy and lactation:** Paxetin should not be used during pregnancy and lactation. **Effects on ability to drive and use machines:** Patients should be advised not to drive a car or operate dangerous machinery until they are sure that Paxetin does not affect them. **Side effects:** The most common: Malaise, pains. Hypertension, syncope, tachycardia. Pruritus. Nausea and vomiting. Weight gain, weight loss. Stimulation of the nervous system, impaired concentration, depression, emotional instability, vertigo. Increased coughing, rhinorrhea. **Overdose:** A wide margin of safety is evident from available data. Experience of paroxetine in overdose has indicated that, in addition to those symptoms mentioned under Side Effects, vomiting, dilated pupils, fever, blood pressure changes, headache, involuntary muscle contractions, agitation, anxiety and tachycardia have been reported. Treatment should consist of general measures employed in the management of overdose with any antidepressant. Early administration of activated charcoal may delay the absorption of Paxetin.

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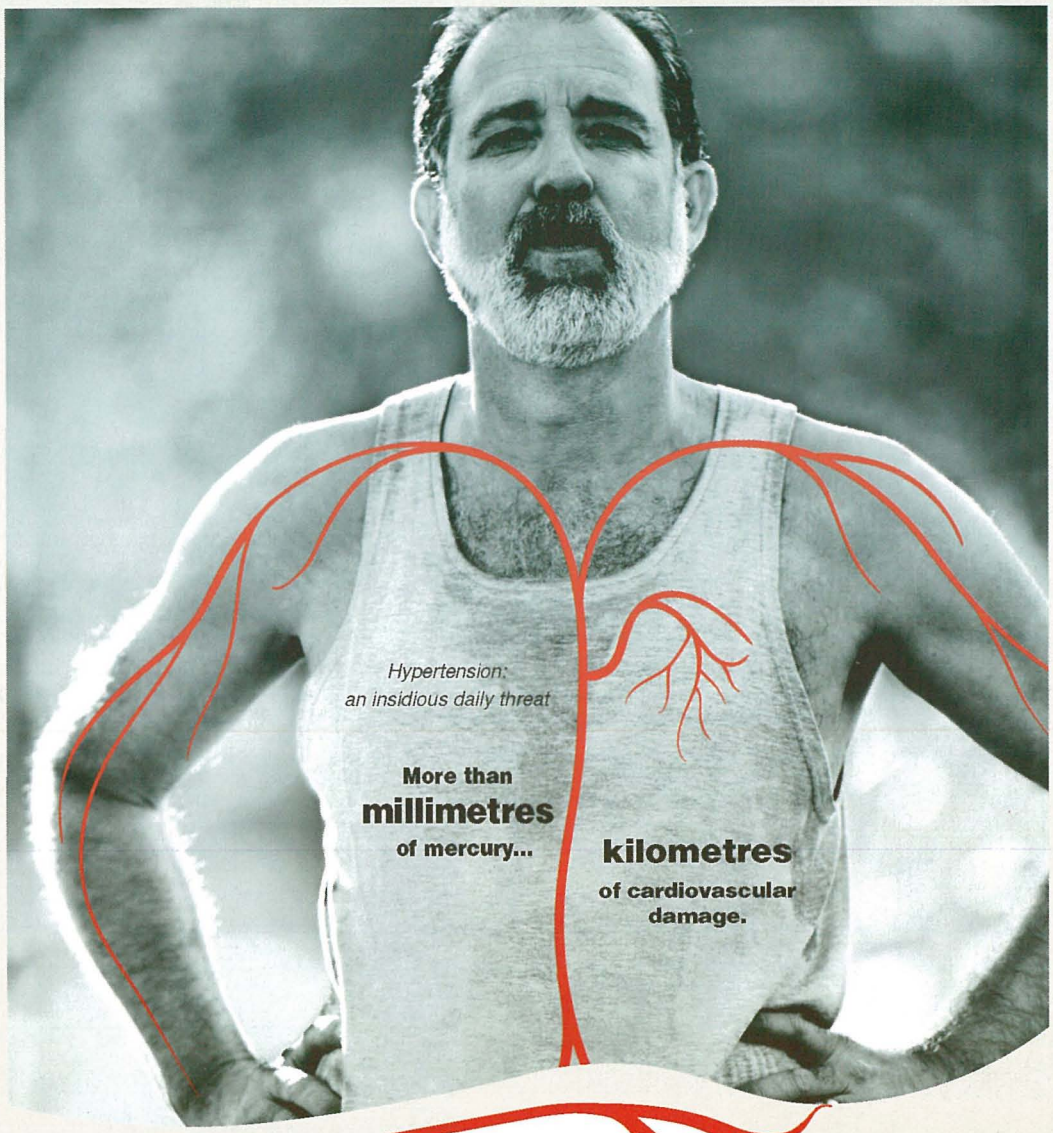

DIOVAN®

Presentation: Valsartan: film-coated tablets of 80 mg and 160 mg. **Indication:** Hypertension, heart failure. **Dosage / Hypertension:** 80 mg once daily. If the fall in blood pressure is inadequate, dosage may be increased to 160 mg, or another antihypertensive (e.g. diuretic) may be added. **Dosage / Heart failure:** Starting dose is 40 mg twicedaily. Uptitration to 80 and 160 mg twice daily as tolerated by patient. **Contraindications:** Known hypersensitivity to the components of this product, pregnancy. **Precautions / Warnings: Hypertension:** Risk of hypotension in sodium- and/or volume-depleted patients, renal artery stenosis, severe renal impairment (creatinine clearance < 10 mL/min), biliary cirrhosis or obstruction. Caution in road users. Concomitant treatment with potassium-sparing diuretics or potassium supplements. Pregnancy and lactation. **Heart failure:** Caution should be observed when initiating therapy in patients with heart failure. The triple combination of an ACE-inhibitor, betablocker and Diovan is not recommended. In patients with severe heart failure, treatment with Diovan may cause impairment of renal function. **Adverse reactions:** Generally similar in incidence to patients receiving placebo in placebo-controlled clinical trials, e.g. headache, dizziness, fatigue. The observed incidence of cough with valsartan in controlled clinical trials was significantly less than that observed with ACE inhibitors and similar to that seen with placebo. Postmarketing experience revealed very rare cases of hypersensitivity reactions (e.g. angioedema), and impaired renal function. Dizziness can occur more often in heart failure patients. Some patients with heart failure have developed increases in blood urea nitrogen, serum creatinine and potassium, usually minor and transient. **Packs:** Diovan 80 mg and 160 mg are supplied in packs of 28 tablets.

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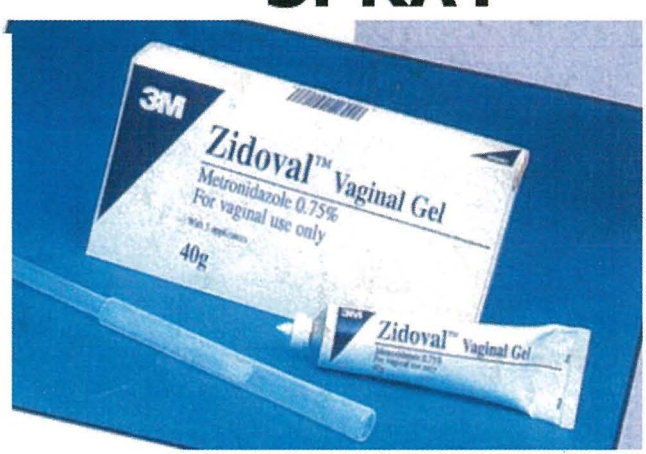

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Hawthorn (L-anżalor is similar). Its fruit which has some astringent property for diarrhea; but was also considered of some benefit for certain heart conditions, high blood pressure, diabetes and as a mild sedative.

Narcis: As a laxative and to lessen vomiting .

Tassel Hyacinth (Basal il-ħnieżer): For kidneys and squashed for skin rashes.

Wild Carrot (Zunnarija Selvaġġa): as a nutrient and believed to aid circulation of blood.

Rocket (Eruka): To help kidneys in passing of water and liquids, and strangely enough thought to move off stones and fragments.

Sponges (Sponoz): belong to the species Phylum Porifera - which mean porebearers. At some point during the period of the Knights, these were used sometimes during certain surgical procedures. Old fishermen maintain that a type of bath sponge used to be collected from the environs of Filfla. However, years back, when diving near Filfla, we never came across any.

Cape Sorel (Qarsu): It contains a small amount of vitamin C. During the French occupation (1798-1800) and also during late 1941 and 1942, people used to collect its tiny bulbs and roots and eat them, sometimes after cleaned in fresh water or after roasting. These have a rather sweet taste.

Cumin was used in past centuries, in connection with tummy ache and certain stomach upsets.

The dreaded dysentery which was a very common condition, often leading to dehydration and death, especially in babies and young children, was treated with a decoction of quince **(L-isfraġel)**.

Vit A (retinol) is an anti-infection vitamin and is vital for well-being. Retinol shortage over a fairly long period, in some cases of about six weeks, sometimes less, interferes with one's ability to see satisfactorily in the dark, resulting in night blindness. This condition affected many French sentries on the bastions and look-out posts during 1798-1800.

Fig-tree (Siġra tat-Tin): Strangely enough, the acrid milky juice exuding from the branches of the fig-tree which is common in the countryside, was used in an effort to remove warts and certain skin excrescences!

Plantain (Biżbula): It was surmised that it had some astringent property and was at times used to lessen bleeding and encourage healing; also topically for ulcers and hemorrhoids. Crushed leaves were sometimes incorporated in poultices.

The Rosemary (Klin) is a bush, recognized by its rather small fleshy leaves, small pale blue flowers and aromatic smell. In the Maltese Islands, it grew in such places as Wied Babu, near Fiddien, Wied il-Qoton, Wied Garnaw and Wied il-Għasel. It was considered a good stimulant, antispasmodic and a positive tonic for the heart and the nervous system. The leaves were boiled and given three times a day or less, to weak or convalescing patients for general health purposes - especially to elderly persons who had suffered from heart attacks and also from mild depression. It was also used as a mouth wash for gingivitis. It was surmised that it helps and acts positively on memory, and at times hard pressed students were advised to have it, during exam periods.

The Friar's cowl, also referred to as small lords and ladies (Garni) which grows in moderate and subtropical climates, including the Mediterranean region, belongs to the Arum group. It is called the Friar's cowl, because part of it resembles somewhat that used by friars. It flowers between December and January. Extract from boiled leaves was used to relieve coughs and for rheumatic discomfort. Also occasionally put on small wounds.

Olives (Żebbuġ): Over the centuries, is one of the most cultivated trees in our islands and is of wide use. Apart from its good nutritive value, used also as a purgative and was thought (not likely) to lessen intermittent fever. There is substance in the old saying that Olives help Man in various ways.

Basil (Ħabaq): is known as an aromatic plant, however it was considered somehow, to be beneficial for congested bronchi.

Honey: The honey produced in Malta and Gozo deserves special mention. It was renowned in ancient times and still is. Cicero had mentioned it as being superior to that of the other countries. It is possible that the name Melita was connected with this produce. Classical writers of the Renaissance and later periods have praised Maltese honey and its delicate aroma which comes from the nectar of the thyme, etc. The life long story of honey is intriguing. It has played a part in Man's life since ancient times because it was then the main source of sweetening. Indeed it is mentioned also together with almond and a few other substances, in a list that Jacob had sent to Pharaoh. (Genesis 43:II). In antiquity, honey was reckoned as a very good digestive. Honey continued to be used for a very long period of years, even during the period of the Knights, both in their hospitals and in country districts in various ways, such as a poultice for wounds and whitlows which were fairly common in the past, before the use of antibiotics. It continued to be used as a medicinal ingredient over the years, at least up to the mid 19th century. It was and is still used as a relief in throat conditions - it is claimed that it has also a very mild limited antiseptic and/or anti-bacterial element. Honey is still fairly popular nowadays. When sugar became available in due course during the period of Knight Hospitallers, sugar was used in medicines, to turn them into a more palatable syrup.

Lettuce (Ħass): A concoction was used topically with the purpose of aiding healing and regenerating new tissue, in areas of pimples, such as the face. Also incorporated in the diet.

Wine: The drinking of wine is steeped in history, since time immemorial. The issue of good wine by the Knights at the Malta hospitals offers some interesting insights. The positive effect of a small amount of wine was realized by the physicians of those times and earlier. Research and analysis show that wine contains a minute amount of vitamins C, B and A; and also iodine, zinc, potassium and magnesium.

In recent years, we have been reading in medical literature that in very moderate amounts - such as a daily glass of genuine wine helps in heart care and somewhat reduces the risk of heart attack and thrombosis. The health giving properties of good wine was appreciated by a wide spectrum of ancient physicians: Sicilians, Italians, Spaniards, Jews, Maltese, Greeks, French, and Germans etc. Furthermore the Romans, Greeks and Egyptians sometimes used wine as an antiseptic. Laboratory analysis has shown that the malvoside contained in wine, has a limited short term antiseptic effect.

Cotton: And now some reference to cotton. Since Phoenician days and down to a little more than one hundred years ago, large areas of agricultural land were still being utilized for the cultivation of cotton, for local needs and for export. A limited amount of cotton, the white variety - a form of gossypium herbaceum which comes from the hairs covering the seed, and also sheep's wool - after being boiled, were sometimes utilized as dressings and in surgery procedures.

Beeswax dissolved in olive oil was sometimes used in the treatment of superficial cuts and minor wounds. Sprains were washed with an infusion of extract of oat grass (il-hafura); and swellings by the application of a liquid from boiled leaves of the common elder.

Oil of cloves: About a century ago, oil of cloves, mixed with grains of chalk or limestone and/or pumice was occasionally placed in carious teeth to allay mild pain and also as a sort of temporary filling. Up to the recent past, it was still being used as part of a dental preparation and used as a lining in temporary fillings. It is still a useful ingredient.

Cloves come from the dried flower-buds of the aromatic plant Eugenia aromatic Linn. In my histological analysis, I had noticed that the petals contain straight-walled epidermal cells without papillae or stomata; and also numerous cluster crystals of calcium oxalate and oil glands.

Propolis: Hippocrates, the famous Greek physician encouraged the use of Propolis for various conditions. This consisted of a resin collected from certain plants, oils and pollen mixed with bees' salivary secretions. It is surmised that it has been used since time immemorial and does help health wise, because of the antibacterial effect (?), gives some resistance against colds, alleviates sore throat and mouth ulcers and helps promote healing of minor cuts.

Hippocrates also advocated the importance of exercise and varied nutrition. At present a type of Propolis is being marketed as a health aid. Hippocrates is synonymous with the Hippocratic Oath which is taken by newly qualified doctors in most of the medical schools in Europe. The original version of the Oath dating from about 400 BC is of historical importance, but is not now considered fully appropriate for today's practice of medicine. The oath was modified repeatedly over the centuries to better reflect the times and circumstances. But the important principles and ethical behaviour embodied in the original oath are still relevant today as they were in the days of Hippocrates of Kos, the most eminent physician of ancient Greece.

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The College's SAC subcommittee has processed and presented all applications to the SAC office. It is regretted that the SAC is taking so long to issue the certificates and the college is doing its utmost to solicit the SAC to complete its admittedly, strenuous exercise.

Answers to questions on Page 13

1. Hypertension is known to be the most common risk factor for congestive heart failure(CHF). Although systolic function is usually preserved in hypertensive heart disease, diastolic function soon becomes abnormal causing pressure overload. The deterioration from left ventricular hypertrophy (LVH) with compensated cardiac function, to symptomatic CHF may be imperceptible, but diastolic filling is usually impaired. End stage hypertensive heart disease is characterized by systolic dysfunction, with dramatic worsening of symptoms. Reduction of BP often results in dramatic improvement in clinical symptoms. One must always rule out other causes of CHF such as occlusive coronary artery disease, hence the need for an angiogram in this case (apart from the fact that presence of a LBBB renders ECG interpretation of ischaemic changes dubious).

2. Identification of hypertensive heart disease rests on proper clinical assessment and non invasive diagnostic investigations. One may suspect LV dilatation and systolic dysfunction by finding lateral displacement of the apical impulse (from the 5th intercostal space, 8-9cm from the mid-line) and the presence of a third heart sound. A sustained apical impulse and a fourth heart sound may suggest LVH.
   Some experience with ECG interpretation may be rewarding by finding evidence of LVH and left atrial enlargement, the latter is a good sign reflecting diastolic dysfunction. The ECG also provides good information on arrhythmias, defective conduction and ischemic changes. Echocardiography is as excellent tool to diagnose hypertensive heart disease. It gives good information about the structure of the LV and determines the presence of LVH and its geometric model, whether it is concentric or eccentric. Concentric LVH is the predominant form in the elderly and middle- aged patients whereas eccentric LVH is uncommon in those under 50 years but can occur in up to 30% of patients over 60. CT scanning and magnetic resonance imaging provide high definition measurements of cardiac function and size but are not indicated for routine use.

3. Results of clinical trials done in the 1990s show that adding an ACE inhibitor to standard treatment decreases the high risk of hospitalizations and mortality related to CHF. The CONSENSUS trial in patients with severe heart failure demonstrated a 12 month mortality rate of 52% in the placebo group compared to 36% in the enalapril group(RR31%). Mortality rates in patients NYHA class II or III in the placebo and enalapril groups of the SOLVD trial were 39.7% and 35.2% respectively.
   Recently, blockers and spironolactone have also been shown to reduce mortality when added to ACE inhibitors, digoxin and diuretics. More recently still, ARBs have been marketed to replace ACE inhibitors in those patients with cough problems. Although we have a vast array of treatments which have evolved over the recent years allowing a better quality of life to our patients with CHF, the morbidity and mortality rates of patients with CHF remain still exceedingly high.

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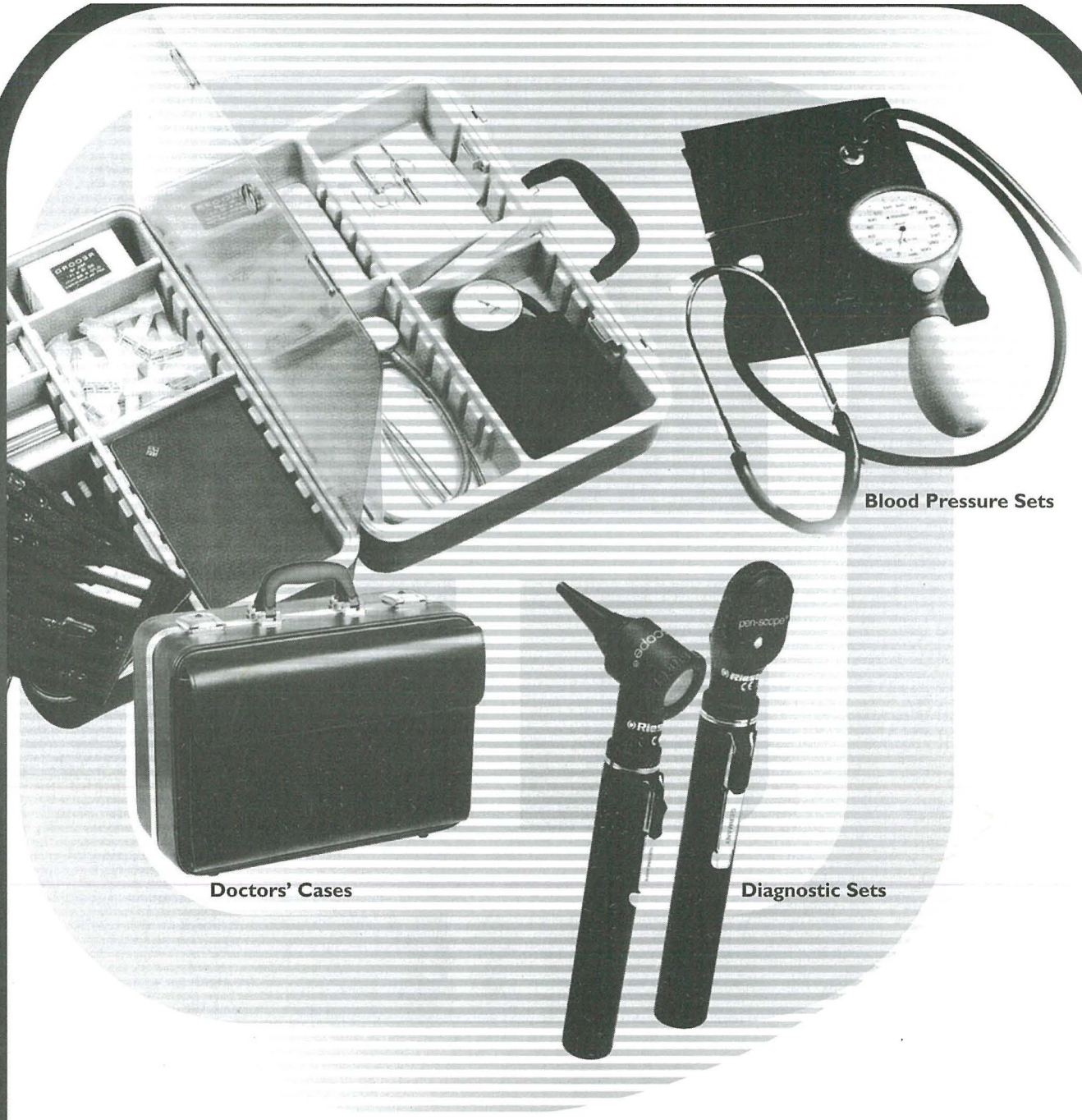
CME in future editions

In accordance with the mission statement of this journal, the CME section is intended to offer an opportunity to discuss issues encountered in the daily practice of famliy medicine. It is hoped that in the future this section will be developed further allowing one to assess and challenge his/her own level of knowledge.



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