the family physician

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JOURNAL OF THE MALTA COLLEGE OF FAMILY DOCTORS

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Editorial

Dear Readers,

May I take this opportunity to comment on the election of the new Council of the Malta College of Family Doctors: see page 28 for details of the members and their responsibilities.

Firstly, I would like to congratulate the old Council members on their hard work performed during the last three-year term. Primarily this meant the establishment of a new Department of Family Medicine at the University, but also that other projects have been possible, such as the Therapeutics Course, the Research Methods Course, the Mediterranean Medical Congress in Malta, and the Transition project, with family doctors now using ICPC in their day-to-day work.

Secondly I would like to welcome the new members to Council, and wish them a most pleasant and productive experience over the next three years.

Finally, I would like to thank our members for the very encouraging electoral response. I hope that we will reward your confidence and merit your continuing support.

Thank you for your confidence in the College.

Jean Karl Soler
Editor

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Cover photo taken by J.K. Soler
Senglea Waterfront

Malta College of Family Doctors

Secretary's Report of College Activities 2001-2

M. R. Sammut
Honorary Secretary, MCFD

1. Council meetings:

Six meetings were held since the last AGM of 17/4/2001, the last of which was on 5/3/2002. Two of these meetings were special half-day meetings, with that on 17th November 2001 discussing a strategy for the College and a new format for the CPD Scheme, while on the 1st December 2001 the new CPD Format was developed further into a proposal for Membership by Assessment. Council members' attendance was as follows:

A P Azzopardi	6
J K Soler	6
F P Calleja	6
M A Borg	5
W Galea	6
A Mifsud	5
M R Sammut	6
J G Pace	5
P Sciortino	6
J P Gauci	2
D Soler	6

2. ICGP Diploma Course in Therapeutics:

Under the coordination of Council member Dr A P Azzopardi, a one-year **Distance Learning Diploma in Therapeutics for General Practice** organised by the Irish College of General Practitioners was launched under the auspices of the MCFD on the 14th September 2001, with 14 local family doctors participating. Cherubino Ltd. kindly accepted to host the two workshops in September and December 2001 led by Dr Margaret O' Riordan and Dr Ailis Ni Riain from the ICGP. A number of companies (AstraZeneca, the Corinthia Group, the Foundation for Medical Services, the Galaxy Hotel, GlaxoSmithKline, Novartis, Pharma-Cos and Solvay Pharma) sponsored other expenses, including the flights and board of the ICGP tutors for these workshops. The College Council agreed that the College cover any remaining expenses.

3. CPD Activities:

- The **Spring CPD Meeting 2001** was held at the Medical School on the 25-27 April 2001 as a **Paediatric Update** in collaboration with the Maltese Paediatric Association, with the following programme:

o Wednesday 25th: 'School Failure' – Dr Doriette Soler, Paediatrician and Mr Stanley Zammit, Educational Psychologist;

o Thursday 26th: 'Common Presenting Symptoms of Malignant Diseases in Childhood' – Dr Victor Calvagna, Paediatrician; 'Heart Disease in Childhood' – Dr Victor Grech, Paediatrician;

o Friday 27th: 'Interactive Paediatric Slide Presentation' – Dr Simon Attard Montalto, Paediatrician.
Sponsors were Charles de Giorgio Ltd.

- A one-day seminar on **'Special concerns of women'** was organised by the College in collaboration with the Malta College of Obstetricians and Gynaecologists and Eli Lilly on 19th May 2001.

o The **Autumn CPD Meeting 2001 'A Psychiatric Update'** was organised on 3-5 October 2001 in collaboration with the Association of Maltese Psychiatrists, with sponsorship by V J Salomone (Trading) Ltd. The programme was as follows:

o Wednesday 3rd: 'The Confused Patient' - Dr Anton Grech, Psychiatrist.

o Thursday 4th: 'The Anxious Patient' – Dr Peter Muscat, Psychiatrist.

o Friday 5th: 'Optimising Treatment Modalities' – Dr Joseph Cassar, Psychiatrist.

- A one-day seminar entitled **Immunisation Update 2001/2** was co-organised on the 27th October 2001 at the Corinthia San Gorg Hotel in collaboration with the Advisory Committee on Immunisation Policy, the Primary Health Care Department, the Department of Paediatrics and GlaxoSmithKline.

- A full-day **Seminar on Epilepsy** 'L-Epilessija fil-Miftuh' was co-organised with the Caritas-Malta Epilepsy Association and the Epilepsy Society of Malta on the 3rd November 2001.

- On the 14th December 2001, a joint CPD Meeting entitled **'Diet and its Role in Prevention: The WHO–CINDI Approach'** was organised

with the **Health Promotion Department** at the Coastline Hotel, Salina, with the following programme: 'Family doctors and health promotion: do we practise what we preach?' - Dr Mario R Sammut; 'Malta and the WHO-CINDI Programme' - Ms Maria Ellul; 'The WHO-CINDI Dietary Guide' - Ms Yvette Azzopardi

- The **Winter CPD Meeting 2002** on **'Diabetes Mellitus in the Maltese Islands'** was held on 23-25 January 2002 at the University of Malta Medical School, in collaboration with the University Department of Medicine. This meeting marked a landmark by being **the first held under the auspices of the new University Department of Family Medicine.** It was sponsored by Servier Malta, and had the following programme:

o Wednesday 23rd: 'Epidemiology of Type 2 Diabetes' - Prof. Joseph Azzopardi, Consultant Physician; 'Gestational Diabetes and its Management' - Mr Charles Savona Ventura, Consultant Obstetrician & Gynaecologist.

o Thursday 24th: 'Paediatric Diabetes and Maturity-Onset Diabetes of the Young' - Dr Antoine G Schranz, Consultant Diabetologist; 'Diabetic Retinopathy' - Mr Thomas Fenech, Consultant Ophthalmic Surgeon.

o Friday 25th: 'The Diabetic Foot' - Dr Mario J Cachia, Consultant Physician; 'Diabetic Nephropathy' - Dr Stephen Fava, Consultant Physician; 'The Metabolic Syndrome and New Frontiers in Diabetes Management' - Prof. Joseph Azzopardi, Consultant Physician.

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

o The 2001 Corinthia **Paediatric Research Fund Annual Lecture** entitled 'Latest developments in childhood leukaemia' and given by Dr Vaskar Saha on Friday 12th October 2001.

o The **Bioethics Conference 2001** held on 26-27 October 2001, with the first evening regarding 'Genetic Testing' and the second 'End of Life Issues'.

4. LOCAL NEWS:

- In July 2001, Council accepted a request from the Health Promotion Department for the College to collaborate in reviewing Malta's versions for GPs and the general public of Europe against Cancer's **'European Code against Cancer - a tool for general practitioners'** published by the European Community. In September 2001, Dr M R Sammut distributed to each Council member for review a different point from the Maltese draft version. Dr M R Sammut, as College Secretary, participated actively in the launch of **Malta's 10-Point Prevention Code Against Cancer** on the 13th February 2002.

- In July 2001, Dr Janet Mifsud, National Chairperson FP5, assisted by Ms Nadine Cauchi and Dr Marvic Sammut, gave a presentation to the College Council on the **EU 5th Framework Programme for Research and Technology Development.** The FP5 team recommended that the easiest way to participate would be to see if there existed a project one could link to. Otherwise one could prepare an original proposal, which would be more difficult.

- In October 2001, a presentation **'A Marketing Proposal for the MCFD'** was made to the College Council by Ms Rosette Thake and Mr Hilary Caruana from Outlook Coop, following which it was decided that an ad-hoc meeting be held by Council on the subject.

- In October 2001, the Council nominated Dr Jean Karl Soler as College representative to a meeting organised by the **Medical Association of Malta** to discuss a **new agreement with the Association of Medical Insurers.** Council asked Dr Soler to present again the College's recommendations made in the Council meeting of the 17th January 2001, together with another that the limit for GP expenses be increased.

- In October 2001, Dr P Sciortono, as Chairman of the College's CME Sub-Committee, recommended the following **Strategy for the future regarding the College's CPD Programme:**

o The presentation be improved as regards venue, publicity and refreshments.

o The academic content be improved according to the needs (not wishes) ascertained according to research. Council here asked Dr Sciortono to analyse the results (with secretarial help) of the survey he had done on the subject.

o The format of teaching be practice-based and informal, taking place in small groups.

o The topics are not always clinically based, but should also include other topics like academic family practice and practice management.

- In November 2001, a ad-hoc Council meeting was held to

discuss **strategic suggestions for the further development of the College**, where the following recommendations were made:

- MARKETING: making use of stationery and rubber-stamps, patient handouts with College logo, a series of articles in the Times Weekender, and the MCFD Newsletter.

- SUB-COMMITTEES to be set up regarding group practices, doctor-patient registration cards, and membership by examination.

- The introduction of MEMBERSHIP/CERTIFICATE COURSES.

- The seeking of STRATEGIC PARTNER/S.

- OTHER TOPICS: a cooperative of private GPs; practice certification; setting up of a College archive; a version of the Journal on CD; small group meetings, e.g. a journal club; multimedia presentations for clinic waiting rooms; targeting children in schools.

- Also in November 2001, Council agreed to push for **revamping the format of the CPD Scheme** by introducing **membership by examination (MMCFD)** to be held over a two-year period, with the first year devoted to the core (theory and principles) of family medicine, and the second year covering clinical aspects of family medicine. The format of the CPD programme would need to be changed to 9 monthly sessions over each year, each session with a form of assessment for those College members who wish to go beyond accreditation to membership by assessment.

- In December 2001, the College Council directed Dr P Sciortino to start making arrangements with the Royal College of General Practitioners for a **Teachers' Course** to be organised locally over 2 or 3 weekends.

- In December 2001, Council approved for distribution a **press release**, prepared by Dr W Galea, recommending health-care funding from tobacco tax.

- In February 2002, Prof. Joseph Cacciottolo requested that the College be an academic sponsor of the local **Chronic Obstructive Lung Disease Guidelines** he co-wrote with Dr Maria Cordina, after having asked 4 members of the College Council to review such guidelines. This request was accepted after e-mail consultation between the members of the College Council

- In March 2002, Drs W Galea, A P Azzopardi and F P Calleja presented Council with a one-page proposal regarding '**Provision of Emergency Medical Cover during Weekends and Public Holidays**'. Council agreed that this proposal be developed further.

- In March 2002, Dr J K Soler announced that **Prof. Henk Lamberts and Dr Inge Okkes** from the Department of Family Practice, University of Amsterdam, will be visiting Malta during April-May 2002 and will be holding two meetings with College members using Transhis.

5. INTERNATIONAL NEWS:

- In June 2001, Dr J K Soler and Dr A Mifsud participated in the **2001 Regional WONCA Europe Conference** in Tampere, Finland.

- In October 2001, Dr J K Soler participated in the **EGPRW meeting** in Gdansk/Gdynia, Poland.

- In November 2001, Dr M R Sammut participated in the **EUROPREV Council Meeting** in Barcelona, Spain.

- In November 2001 Prof. Dame Lesley Southgate, **President of the Royal College of General Practitioners**, wrote to thank the College for its encouragement and support expressed in an e-mail sent by Hon. Secretary Dr M R Sammut. The contents of such e-mail were published in the December 2001 edition of the British Journal of General Practice.

- In January 2002 Dr Daniel J Ostergaard, Vice President International and Interprofessional Activities of the **American Academy of Family Physicians**, wrote to congratulate the College on its role in the establishment of the Department of Family Medicine at the Malta Medical School.

6. Membership and Accreditation:

- **Membership at present stands at 138.**

- **Twenty-seven College members were accredited for 2001**, 13 of which have maintained their accreditation status for the eleven consecutive years since 1991.

7. College Journal and Newsletter:

- In March 2002, Council accepted the request of Dr J K Soler, Editor of the **College Journal**, that the **print run** be raised from 1000 to 1500 to cater for recently qualified doctors and for copies being sent abroad. Dr Soler

announced with regret the **resignation** of Dr Wilfred Galea from the Journal's Editorial Board, which now consisted of just two Maltese members (himself and Dr M R Sammut) and Prof. Christos Lionis from Greece.

- Two issues of the **College Journal** (December 2000 and June 2001) were published since the last AGM.

o The **December 2000 issue** (No. 19) marked an important change in name to **'The Family Physician / It-Tabib tal-Familja'** and its launch as an international Mediterranean Journal of Family Medicine. Also from this issue, the Journal started accepting papers from other Mediterranean countries, commencing with an article from Israel. Moreover, all Family Medicine articles are now being reviewed, beginning with the two GP-related articles in this issue, namely 'Primary Care Services in Malta: Provision, Utilisation and Reform' and 'Utilisation of Complementary and Alternative Medicine in Primary Care – What are the Relations between it and Conventional Medicine?'

o The **June 2001 issue** (No. 20) incorporated two articles related to family/general practice. These were entitled 'Ethical Issues in Family Practice' and 'Paediatric Heart Disease in General Practice'.

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

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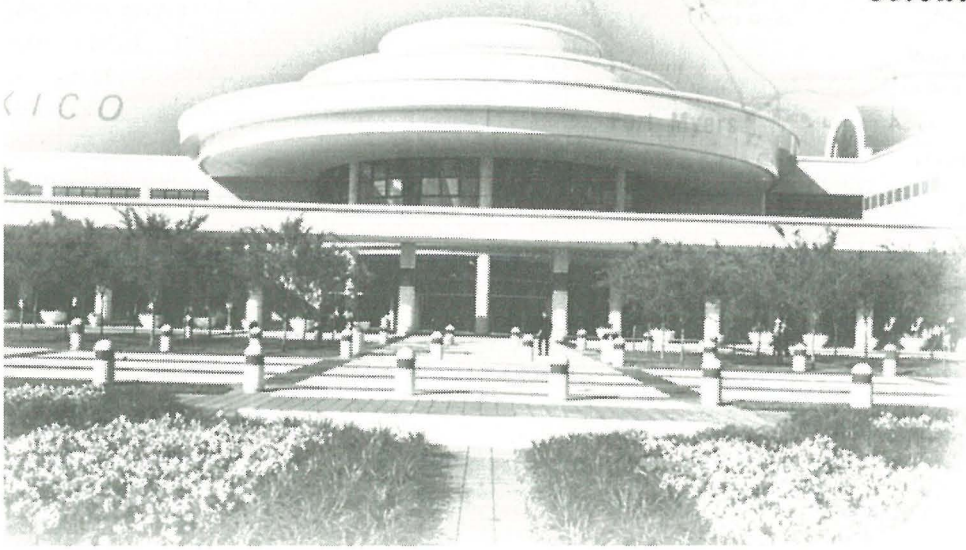

Tightening Tobacco Control Legislation in Malta: A National Health Promotion Initiative on Smoking

M. R. Sammut
Senior Medical Officer in Primary Health Care

ABSTRACT

Introduction: In Malta, individual smokers, doctors and the adult general public are recognising the ill effects of smoking, and are seeking to do stng adults and, more importantly, to trigger off a similar reduction among adolescents, with a consequent protection against disease and death.

Method: Local initiatives against smoking were compared to the WHO - World Health Organisation's Ten-Point Programme for Successful Tobacco Control, to a WHO model law for comprehensive tobacco control, and to European Union directives and resolutions.

Results: While procedures involving health education, smoking cessation, professionals' smoke-free example, and fiscal policies are all being implemented, Maltese tobacco control laws and regulations are still deficient.

Conclusion: A health promotion strategy of tightening tobacco control legislation needs to be introduced in Malta forthwith. This includes strict enforcement, more severe penalties, banning of sales to adolescents and in places frequented by them, the prohibition of smoking in enclosed public places, a total ban on advertising and sponsorship, and the introduction of maximum tar-yield levels and conspicuous and effective health warnings on all tobacco products. An overall priority is the setting-up of a coordinating tobacco control authority to effectively manage all efforts to stem the tobacco epidemic.

Keywords: Tobacco control, legislation, Malta, health promotion.

INTRODUCTION

The Ottawa Charter for Health Promotion describes health promotion as "the process of enabling people to increase control over, and to improve, their health"[1]. It consists of the informed application of any combination of interventions (educational, legal, fiscal, economic, environmental and organisational) designed to facilitate the achievement of health and the prevention of disease. Health promotion can work at three levels: at the *primary* level to prevent illness or maintain health; at the *secondary* level to stop or reverse the process of illness; and at the *tertiary* level to prevent long-term sequelae or ameliorate the effects of illness[2].

After undertaking an assessment of needs in respect of tobacco and health in Malta, this initiative goes on to set appropriate aims and objectives. Strategies of intervention are then recommended, followed by methods of evaluation and feedback.

NEEDS ASSESSMENT

Purpose

A need is something people could benefit from. Just as a doctor systematically assesses the needs of a patient before prescribing the effective treatment, the optimal utilisation of the resources of health services (including health promotion) depends on a systematic assessment of the healthcare needs of the population[3]. Any worthwhile health promotion initiative therefore should target an issue that has an appreciable effect on health.

Smoking is such an issue. The World Health Organisation has stated: "Tobacco products have no safe level of consumption. They are the only legal consumer products that cause ill health and premature death when used exactly as the manufacturer intends. Unless concerted action is taken quickly, 250 million of today's children will die prematurely from an avoidable cause - tobacco use."[4] In Malta smoking is considered as the foremost preventable cause of premature death and disease[5].

Process

A comprehensive assessment will include ascertaining the views of the professionals and the needs of the general public and the individual smoker.

The professionals' view

The role of health-care personnel is important in setting a non-smoking example to the public in general and their patients in particular. While in 1989 25% of Maltese doctors smoked[6], preliminary results of a 1999 survey of members of the Medical Association of Malta revealed that this percentage has dropped to 13% (unpublished data). A study carried out in 2000 for EUROPREV (European Network for Prevention and Health Promotion in Family Medicine and General Practice) showed that 12% of family doctors in Malta smoke cigarettes while 3% smoke cigars or the pipe (unpublished data).

The general public

According to World Health Organisation figures, in the early-to-mid 1990s 42% of males and 24% of females in developed countries smoked, while in developing countries the corresponding percentages were 48% and 7% respectively[7]. The morbidity and mortality effects of smoking are well known. According to WHO estimates, there are currently 4 million deaths a year from tobacco, a figure expected to rise to about 10 million by the 2020s or early 2030s. By that date, based on current smoking trends, tobacco is predicted to be the leading cause of disease burden in the world, causing about one in eight deaths. Seventy per cent of those deaths will occur in developing countries[8].

In Malta, while 54% of 25-64 year old men and 20% of women (of the same age) smoked in the mid-1980s[9], in 1995 this percentage for men dropped to 38% with that for women only marginally decreasing to 17%[10]. Among Maltese adolescents too, cigarette smoking is common: 31% of the 20,815 schoolchildren aged 11-16 who took part in a Caritas/Pride/DISCERN Survey stated that they had smoked at least one cigarette in 1990[11]. A follow-up survey in 1998 of a sample size of 1,100 schoolchildren showed that cigarette use was still high at 32%[12].

The WHO calculates that smoking causes 90% of cancer of the trachea, bronchus and lung, 75% of chronic bronchitis and emphysema, and 25% of ischaemic heart disease. Applying these percentages to local reported deaths from these diseases, the number of yearly deaths in Malta attributable to smoking had risen by 28% from 289 in 1987 to 371 in 1999, i.e. *one death every day* (Agius Muscat, H., personal communication).

Passive smoking (environmental tobacco smoke - ETS) is an established cause of disease and death. The harmful effects include asthma, middle ear infection and bronchitis or pneumonia in children, heart disease and lung cancer[13]. Researchers from the University of Minnesota Cancer Center reported a derivative of a tobacco-specific lung carcinogen (NNK) found in the urine of non-smokers exposed to ETS under real-life conditions, reportedly the first hard evidence of how passive smoking can cause cancer (214th National Meeting and Exposition of the American Chemical Society, Las Vegas, Nevada, USA, Sept. 7-11, 1997). A comprehensive meta-analysis of ten cohort and eight case-control studies has concluded that exposure to ETS in the home or workplace increases a person's risk of coronary heart disease by about 25%[14]. A phone-in survey carried out in Malta indicated that 77% of callers to a popular local television programme were against smoking in public places[15]. Even Malta's members of parliament have designated all indoor areas of the House of Representatives in the Presidential Palace, Valletta as smoke-free zones (apart from specially designated areas)[16]. This shows that the majority of the Maltese population have come to appreciate such dangers of ETS.

The individual smoker

In a study of the smoking habits of applicants for smoking cessation clinics in Malta, it was found that:

- 38% smoked all the time and everywhere,
- 15% when nervous, upset or angry,
- 12% with or after food or drink, and
- 9% at work.

Seventy-two per cent of smokers thought they would be much healthier after quitting. This cohort of smokers also expressed a strong desire to quit, as shown by the results that about nine out of ten believed in quitting with help and had tried quitting more than once. Over half thought they would not be smoking a year later[17].

Conclusion of needs assessment

It may therefore be said that individual smokers, doctors and the adult general public are recognising the ill effects of smoking, and are seeking to do something about it. This is however not the case with adolescents, where smoking in 1998 remained at the same level it had been eight years previously. There is an evident need for a health promotion initiative on smoking to accelerate the reduction in smoking among adults and, more importantly, to trigger off a similar reduction in smoking among adolescents.

SETTING AIM AND OBJECTIVES

Aim

The aim of this initiative is the improvement of the health status of the Maltese population in general (primary prevention) and of smokers in particular (secondary and tertiary prevention).

Objectives

In chapter 27 (entitled 'Tobacco Use') of 'Healthy People 2010', the United States' health goals for this decade, no less than 21 objectives are enumerated regarding tobacco use alone[18], while the WHO document Health21 lists 21 general objectives[19]. On the other hand, the UK Department of Health's 'Saving Lives: Our Healthier Nation' rejects "the previous Government's scattergun targets" and limits its objectives to

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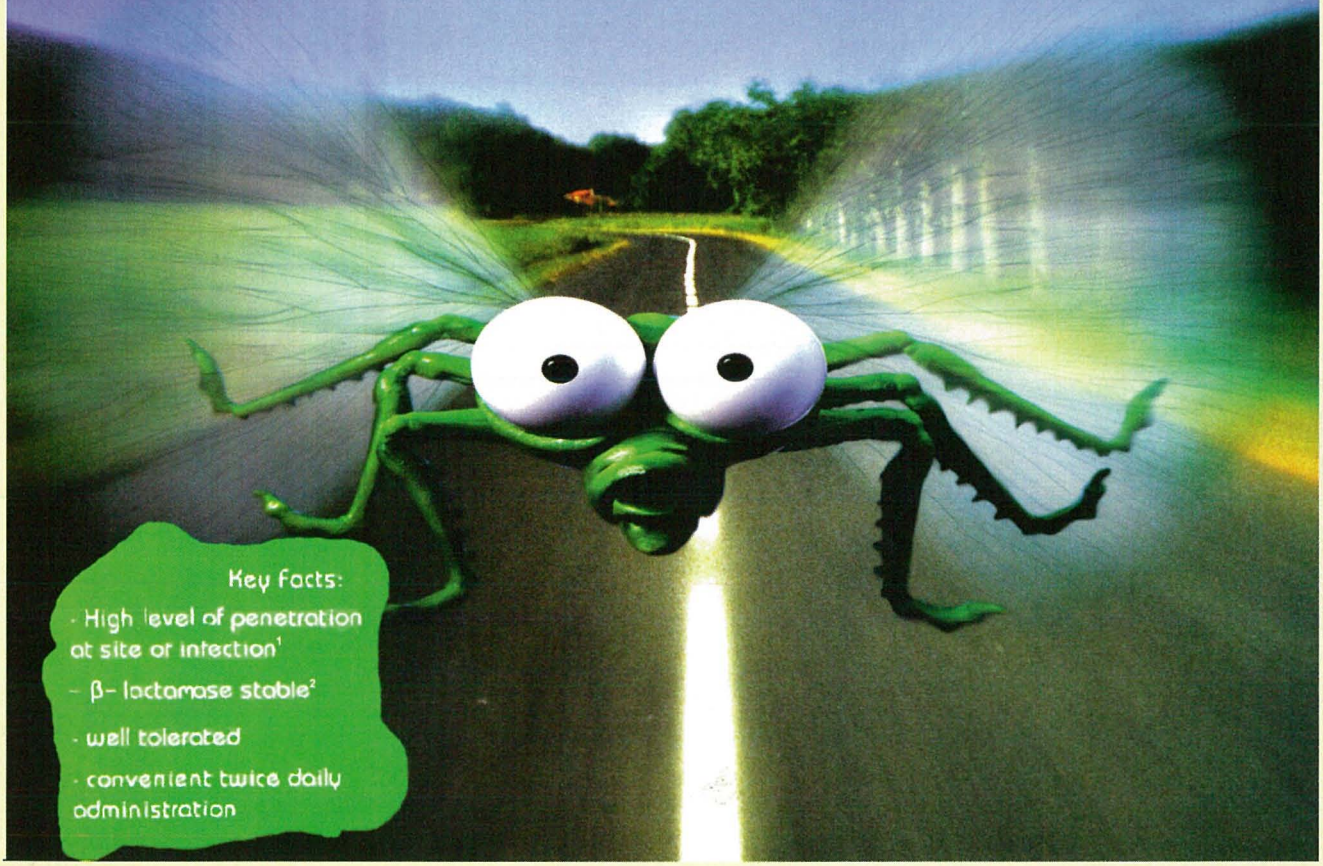

Abbreviated Prescribing Information **Uses** Zinnat is indicated for infections of upper and lower respiratory tract, skin and soft tissue. **Presentations** White tablets containing 125 mg, 250 mg and 500 mg cefuroxime axetil, suspension containing 125 mg cefuroxime axetil per 5 ml. **Dosage** *Adults:* Most infections - 250 mg twice daily. Lower respiratory tract infection - 250 mg twice daily. Pneumonia - 500 mg twice daily. Urinary tract infection - 125 mg twice daily. Pyelonephritis - 250 mg twice daily. Uncomplicated gonorrhoea - 1 g single dose. *Children*: Most infections - 125 mg twice daily. Otitis media - 3 months to 2 years 125 mg twice daily, 2 years to 12 years 250 mg twice daily. Tablets should not be chewed or crushed and therefore are not suitable for children under five years of age. Zinnat should be taken after food for optimum absorption. **Contra-indications** Hypersensitivity to cephalosporin antibiotics. **Precautions** Zinnat may, in general, be given to patients who are hypersensitive to penicillins, although cross-reactions have been reported with some cephalosporins and special care indicated in patients who have experienced anaphylactic reaction to penicillin. Cefuroxime axetil should be administered with caution during early months of pregnancy. **Side effects** Gastrointestinal disturbances including diarrhoea, nausea and vomiting had been reported, these are generally mild and transient in nature. As with all broad spectrum antibiotics, there have been rare reports of pseudomembranous colitis. Rarely, hypersensitivity reactions, eosinophilia and transient increase of hepatic enzyme levels have been noted. **Package quantities** All strengths of tablets are supplied in foil strips in packs of 10. Suspension is supplied in bottles containing 50 ml and 100 ml.

References:

1. Perry CM & Brogden RN. Drugs 1996; 52(1): 125-158.
2. ZINNAT Approved Product Information.

GlaxoWellcome

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priority areas, setting "tougher but attainable targets"[20]. This is precisely what this strategy plans to do.

While the chance of getting a myocardial infarction is halved 24 hours after stopping smoking (British Medical Association Annual Scientific Meeting in Malta, 22-26 September 1992), according to a U.S. Surgeon General Report the added risk of disease suffered by smokers is reduced by a half or more within one year of quitting, and then declines more slowly to reach the risk of a never-smoker after some years[21]. A recent UK study in fact concluded that quitting smoking before middle age avoids more than 90% of the risk attributable to tobacco[22].

Therefore, based on recent French experience following the introduction of tough tobacco control legislation[23], the first objective of this initiative is:

Objective 1: The reduction of the number of smokers in the general population by 15% over 5 years.

The measures proposed for this objective include:

Direct Measures:

- Population survey through the national census (next due in 2005);
- Targeted surveys, such as repetitions of those of adolescents carried out previously[11, 12].

Proxy Measures:

- Sales of tobacco (taking sales to the tourist population as a constant factor);
- Sales of smoking-cessation pharmaceuticals;
- Applications for smoking cessation clinics organised by the Health Promotion Department of Malta;
- Participation rates in 'Quit & Win' campaigns, also organised by the Health Promotion Department.

The second objective is based on the targets set by the UK Department of Health[20] and comprises:

Objective 2: The reduction of mortality rates from smoking-related diseases:

- *respiratory cancer in people under 75 years by 20% over 15 years;*
- *chronic bronchitis and emphysema in people under 75 years by 30% over 15 years;*
- *coronary heart disease in people under 75 years by 40% over 15 years.*

Yearly mortality rates of the above diseases are a *direct measure* of this objective and may be obtained from the National Mortality Register kept at the Malta Department of Health Information.

DEFINING THE STRATEGY

From the WHO Ten-Point Programme for Successful Tobacco Control[4] (see Table 1), point 4 emphasises the importance of **health education**, **smoking cessation** and the **smoke-free example** of healthcare professionals. This point is being actively pursued by the Health Promotion Department through a number of educational and other activities, amongst which the organisation of smoking cessation clinics since 1991[17]. As regards smoke-free example, the needs assessment (above) has shown a drop by one-half in the smoking rate among doctors over the past ten years.

The other nine points of the programme refer to **public policy** issues. Points 2, 3 & 9 concern the use of **fiscal policies** to discourage the use of tobacco, of tobacco taxes to finance other tobacco control measures, and of economic alternatives to tobacco growing and manufacturing. While the last of

	W.H.O. TEN-POINT PROGRAMME FOR SUCCESSFUL TOBACCO CONTROL
1.	Protection for children from becoming addicted to tobacco.
2.	Use of fiscal policies to discourage the use of tobacco, such as tobacco taxes that increase faster than the growth in prices and income.
3.	Use a portion of the money raised from tobacco taxes to finance other tobacco control and health promotion measures.
4.	Health promotion, health education and smoking cessation programmes. Health workers and institutions set an example by being smoke-free.
5.	Protection from involuntary exposure to environmental tobacco smoke (ETS).
6.	Elimination of socioeconomic, behavioural and other incentives which maintain and promote use of tobacco.
7.	Elimination of direct and indirect tobacco advertising, promotion and sponsorship.
8.	Controls on tobacco products, including prominent health warnings on tobacco products and any remaining advertisements; limits on and mandatory reporting of toxic constituents in tobacco products and tobacco smoke.
9.	Promotion of economic alternatives to tobacco growing and manufacturing.
10.	Effective management, monitoring and evaluation of tobacco issues.

Table 1: WHO Ten-Point Programme for Successful Tobacco Control[4]

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The role of health-care personnel is important in setting a non-smoking example to the public in general and their patients in particular. While in 1989 25% of Maltese doctors smoked[6], preliminary results of a 1999 survey of members of the Medical Association of Malta revealed that this percentage has dropped to 13% (unpublished data). A study carried out in 2000 for EUROPREV (European Network for Prevention and Health Promotion in Family Medicine and General Practice) showed that 12% of family doctors in Malta smoke cigarettes while 3% smoke cigars or the pipe (unpublished data).

The general public

According to World Health Organisation figures, in the early-to-mid 1990s 42% of males and 24% of females in developed countries smoked, while in developing countries the corresponding percentages were 48% and 7% respectively[7]. The morbidity and mortality effects of smoking are well known. According to WHO estimates, there are currently 4 million deaths a year from tobacco, a figure expected to rise to about 10 million by the 2020s or early 2030s. By that date, based on current smoking trends, tobacco is predicted to be the leading cause of disease burden in the world, causing about one in eight deaths. Seventy per cent of those deaths will occur in developing countries[8].

In Malta, while 54% of 25-64 year old men and 20% of women (of the same age) smoked in the mid-1980s[9], in 1995 this percentage for men dropped to 38% with that for women only marginally decreasing to 17%[10]. Among Maltese adolescents too, cigarette smoking is common: 31% of the 20,815 schoolchildren aged 11-16 who took part in a Caritas/Pride/DISCERN Survey stated that they had smoked at least one cigarette in 1990[11]. A follow-up survey in 1998 of a sample size of 1,100 schoolchildren showed that cigarette use was still high at 32%[12].

The WHO calculates that smoking causes 90% of cancer of the trachea, bronchus and lung, 75% of chronic bronchitis and emphysema, and 25% of ischaemic heart disease. Applying these percentages to local reported deaths from these diseases, the number of yearly deaths in Malta attributable to smoking had risen by 28% from 289 in 1987 to 371 in 1999, i.e. *one death every day* (Agius Muscat, H., personal communication).

Passive smoking (environmental tobacco smoke - ETS) is an established cause of disease and death. The harmful effects include asthma, middle ear infection and bronchitis or pneumonia in children, heart disease and lung cancer[13]. Researchers from the University of Minnesota Cancer Center reported a derivative of a tobacco-specific lung carcinogen (NNK) found in the urine of non-smokers exposed to ETS under real-life conditions, reportedly the first hard evidence of how passive smoking can cause cancer (214th National Meeting and Exposition of the American Chemical Society, Las Vegas, Nevada, USA, Sept. 7-11, 1997). A comprehensive meta-analysis of ten cohort and eight case-control studies has concluded that exposure to ETS in the home or workplace increases a person's risk of coronary heart disease by about 25%[14]. A phone-in survey carried out in Malta indicated that 77% of callers to a popular local television programme were against smoking in public places[15]. Even Malta's members of parliament have designated all indoor areas of the House of Representatives in the Presidential Palace, Valletta as smoke-free zones (apart from specially designated areas)[16]. This shows that the majority of the Maltese population have come to appreciate such dangers of ETS.

The individual smoker

In a study of the smoking habits of applicants for smoking cessation clinics in Malta, it was found that:

- 38% smoked all the time and everywhere,
- 15% when nervous, upset or angry,
- 12% with or after food or drink, and
- 9% at work.

Seventy-two per cent of smokers thought they would be much healthier after quitting. This cohort of smokers also expressed a strong desire to quit, as shown by the results that about nine out of ten believed in quitting with help and had tried quitting more than once. Over half thought they would not be smoking a year later[17].

Conclusion of needs assessment

It may therefore be said that individual smokers, doctors and the adult general public are recognising the ill effects of smoking, and are seeking to do something about it. This is however not the case with adolescents, where smoking in 1998 remained at the same level it had been eight years previously. There is an evident need for a health promotion initiative on smoking to accelerate the reduction in smoking among adults and, more importantly, to trigger off a similar reduction in smoking among adolescents.

SETTING AIM AND OBJECTIVES

Aim

The aim of this initiative is the improvement of the health status of the Maltese population in general (primary prevention) and of smokers in particular (secondary and tertiary prevention).

Objectives

In chapter 27 (entitled 'Tobacco Use') of 'Healthy People 2010', the United States' health goals for this decade, no less than 21 objectives are enumerated regarding tobacco use alone[18], while the WHO document Health21 lists 21 general objectives[19]. On the other hand, the UK Department of Health's 'Saving Lives: Our Healthier Nation' rejects "the previous Government's scattergun targets" and limits its objectives to

priority areas, setting "tougher but attainable targets"[20]. This is precisely what this strategy plans to do.

While the chance of getting a myocardial infarction is halved 24 hours after stopping smoking (British Medical Association Annual Scientific Meeting in Malta, 22-26 September 1992), according to a U.S. Surgeon General Report the added risk of disease suffered by smokers is reduced by a half or more within one year of quitting, and then declines more slowly to reach the risk of a never-smoker after some years[21]. A recent UK study in fact concluded that quitting smoking before middle age avoids more than 90% of the risk attributable to tobacco[22].

Therefore, based on recent French experience following the introduction of tough tobacco control legislation[23], the first objective of this initiative is:

Objective 1: The reduction of the number of smokers in the general population by 15% over 5 years.

The measures proposed for this objective include:

Direct Measures:

- Population survey through the national census (next due in 2005);
- Targeted surveys, such as repetitions of those of adolescents carried out previously[11, 12].

Proxy Measures:

- Sales of tobacco (taking sales to the tourist population as a constant factor);
- Sales of smoking-cessation pharmaceuticals;
- Applications for smoking cessation clinics organised by the Health Promotion Department of Malta;
- Participation rates in 'Quit & Win' campaigns, also organised by the Health Promotion Department.

The second objective is based on the targets set by the UK Department of Health[20] and comprises:

Objective 2: The reduction of mortality rates from smoking-related diseases:

- *respiratory cancer in people under 75 years by 20% over 15 years;*
- *chronic bronchitis and emphysema in people under 75 years by 30% over 15 years;*
- *coronary heart disease in people under 75 years by 40% over 15 years.*

Yearly mortality rates of the above diseases are a *direct measure* of this objective and may be obtained from the National Mortality Register kept at the Malta Department of Health Information.

DEFINING THE STRATEGY

From the WHO Ten-Point Programme for Successful Tobacco Control[4] (see Table 1), point 4 emphasises the importance of **health education**, **smoking cessation** and the **smoke-free example** of healthcare professionals. This point is being actively pursued by the Health Promotion Department through a number of educational and other activities, amongst which the organisation of smoking cessation clinics since 1991[17]. As regards smoke-free example, the needs assessment (above) has shown a drop by one-half in the smoking rate among doctors over the past ten years.

The other nine points of the programme refer to **public policy** issues. Points 2, 3 & 9 concern the use of **fiscal policies** to discourage the use of tobacco, of tobacco taxes to finance other tobacco control measures, and of economic alternatives to tobacco growing and manufacturing. While the last of

	W.H.O. TEN-POINT PROGRAMME FOR SUCCESSFUL TOBACCO CONTROL
1.	Protection for children from becoming addicted to tobacco.
2.	Use of fiscal policies to discourage the use of tobacco, such as tobacco taxes that increase faster than the growth in prices and income.
3.	Use a portion of the money raised from tobacco taxes to finance other tobacco control and health promotion measures.
4.	Health promotion, health education and smoking cessation programmes. Health workers and institutions set an example by being smoke-free.
5.	Protection from involuntary exposure to environmental tobacco smoke (ETS).
6.	Elimination of socioeconomic, behavioural and other incentives which maintain and promote use of tobacco.
7.	Elimination of direct and indirect tobacco advertising, promotion and sponsorship.
8.	Controls on tobacco products, including prominent health warnings on tobacco products and any remaining advertisements; limits on and mandatory reporting of toxic constituents in tobacco products and tobacco smoke.
9.	Promotion of economic alternatives to tobacco growing and manufacturing.
10.	Effective management, monitoring and evaluation of tobacco issues.

Table 1: WHO Ten-Point Programme for Successful Tobacco Control[4]

the three may not be so relevant to Malta, tobacco taxes *have* been raised annually over recent years. In fact, tax increases have been shown to be the single most effective intervention to reduce demand for tobacco[24]. A further step to be implemented is the channelling of part of such taxes towards the funding of health promotion and medical research[25], and towards the replacement of sponsorship of sports and cultural activities currently supported by the tobacco industry.

The remaining six points of the WHO Programme concern **legislation**: the banning of sales to and advertising targeted at children; protection from involuntary exposure to environmental tobacco smoke; the elimination of socio-economic, behavioural and other incentives which maintain and promote the use of tobacco (including direct and indirect tobacco advertising, promotion and sponsorship); controls on tobacco products, including prominent health warnings on tobacco products; and limits on and mandatory reporting of toxic constituents in tobacco products and tobacco smoke. Effective management, monitoring and evaluation of these tobacco issues are essential.

After comparing the local situation with international experience and evidence, it is evident that local tobacco control laws and regulations are still deficient, and this health promotion initiative on smoking thus proposes the tightening of such legislation as its strategy for Malta.

Health promotion approach & practice-model

Changes in tobacco use can be brought about in the environment and social structures using an authoritative/collective model with a top-down and expert-led approach, as long as necessary preparations are made for political backing and public support[26, 27]. While the tobacco industry advocates self-regulation, it is well known that the implementation of a tobacco control policy depends on legislation that is comprehensive, closely monitored and strictly enforced[28]. As declared by Simpson, "the evidence that tobacco control policy cannot achieve maximum effectiveness without legislation becomes more abundant every year"[28].

International experience and evidence

Every country has to work out a specific strategy that is prepared taking into account international factors. Existing legislation in Malta was compared to a model of legislation for comprehensive tobacco control recommended by the World Health Organisation (Collishaw, N. E., former Acting Chief, WHO Tobacco or Health Unit, personal communication). The purpose of this model "is to provide a legislative response to a national public health problem of substantial and pressing concern and, in particular,

(a) to protect the health of the people in the light of conclusive evidence implicating exposure to tobacco smoke in the incidence of numerous debilitating and fatal diseases;
(b) to protect young persons and others, to the extent that is reasonable, from inducements to use tobacco products and consequent dependence on them;
(c) to enhance public awareness of the hazards of tobacco use by ensuring the effective communication of pertinent information to consumers of tobacco products;
(d) to protect people to the extent that is reasonable and possible from the hazards of involuntary exposure to tobacco smoke; and
(e) to regulate tobacco products and the distribution of these products in a way that is consistent with public health goals."

Investigations by Joosens[29] have concluded that a wide tobacco control strategy, incorporating advertising bans, is needed to maintain the downward trends in consumption shown to have followed a ban in tobacco advertising[30]. The WHO document Health21 states that, together with greater availability of treatment products and cessation advice, the tighter regulation of tobacco products and a ban on the advertising and sponsorship of tobacco products will reduce the annual toll of up to 2 million deaths expected during the next 20 years[19]. The same document goes on to cite a case in point, namely the Evin Law in France. Five years after the introduction of this 1991 law (which banned cigarette advertising, created smoke-free public places and increased prices), cigarette consumption in France had fallen by 16%[23]. Thus, effective legislation does seem to reduce tobacco consumption.

Legislation in Malta: present and proposed

Regarding local legislation on smoking and young people, at present this simply bans the selling of tobacco to those under 16 years of age. Besides voluntary measures against ETS taken in selected cases (Air Malta European flights, one guest-house, a handful of restaurants and some workplaces), smoking is presently only banned in public transport, cinemas, theatres, hospitals, clinics or other health institutions, local television studio broadcasts and schools. Advertising is prohibited on television, radio (or other broadcasting medium) and in cinemas, but

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there are no controls on sponsorship by tobacco companies (with a prominent tobacco brand in fact sponsoring the local premier football league). Health warnings are inconspicuous and ineffective, being confined to cigarette packets on one side only. However, the main problem is the lack of enforcement of these laws and regulations[31, 32].

As such, the following are the main components of the strategy proposed to tighten local legislation, based on the WHO model tobacco law (cited above) and European Union (EU) directives and resolutions (in the light of Malta's present negotiations to join the EU):

1. *Enforcement* regulations to designate health inspectors, police officers and local wardens as being responsible to enforce tobacco legislation.
2. The updating of tobacco legislation to make the breaking of such legislation liable to more severe *penalties* (and serve as a deterrent).
3. *Sales* legislation to be revised so as to protect the young through enforcing the ban of single cigarettes, and by prohibiting the sale of tobacco products in schools, colleges, universities, and sports or athletic facilities (amongst others). Sales through automated vending machines, using self-service displays, by mail order or the Internet, and to persons less than 18 years (presently under 16) would also be banned.
4. Regulations banning *smoking in enclosed public places* (with the exception of designated no-smoking rooms) to extend the present limited ban. These would come to include establishments where services are provided to the public, where elderly persons are received, where children or young people are received or housed, where higher education and vocational training are given, in radio or TV studios open to the public, where exhibitions are held, where sports are practised, and in enclosed premises of ports and airports[33].
5. Tobacco *advertising* regulations to implement a total ban of advertising except at point of sale (with a one-year delay in respect of the press), and of *sponsorship* (after a two-year delay) and other forms of tobacco promotion (including free samples, discounts, gifts and contests), and to prohibit the use of tobacco trademarks on non-tobacco goods[34]. In spite of the directive referred to here being annulled during a landmark case in the European Court of Justice in Luxembourg during October 2000, the European Commission is to press ahead with legislation to phase out tobacco advertising and sponsorship inside the E.U.[35]
6. The introduction of conspicuous and effective *health warnings* on the front, back and one side of cigarette packets, and the extension of such warnings to all forms of tobacco[36, 37]. Moreover, maximum *tar-yield* regulations are required to reduce the health damage caused by tar in cigarettes[38].

Time frame, financial requirements, feasibility and viability

The time frame for the implementation of such legislation must conform with the schedule imposed on the country by its negotiations for accession to the European Union.

A specific financial requirement incurred by the government would be the arrangement with a specialised overseas laboratory to perform spot checks for tar levels in cigarettes (in addition to tests routinely done by the local tobacco industry). The government would also need to monitor the proper enforcement of legislation, which always costs money. Other expenses would of course be incurred by enclosed public establishments in setting up specific smoking rooms, and by tobacco companies in altering health warnings on tobacco products. The Maltese government can rest assured that a comprehensive tobacco control policy is not likely to harm the economy[24].

As such, besides the expected opposition of the tobacco industry to any measures that would affect their sales, it is envisaged that there would be no difficulties regarding the feasibility and viability of such legislative strategy against smoking.

EVALUATION & FEEDBACK

Point 10 of the WHO Ten-Point Programme for Successful Tobacco Control emphasises the importance of effective management, monitoring and evaluation of tobacco issues[4]. Evaluation is essential to appraise the success (or failure) of an intervention, so that the necessary feedback is available for the planning process.

Process

Both the process and the impact/outcome are evaluated. Process evaluation assesses the implementation of the strategy, in this case the tightening of local tobacco control legislation. This can be performed *prior* to the actual coming-into-force of the legislation by initially publishing it as a white paper to enable comments from interested parties and the general public. The process can also be evaluated *after* the

strategy is initiated through qualitative techniques including observations, interviews and case studies.

Impact and Outcome

Impact evaluation assesses the immediate effect of a health promotion strategy, while evaluation of the outcome is concerned with the long-term consequences. As legislative action uses the authoritative model for social change, the latter will only occur after a number of years have passed, therefore permitting only the long-term outcome to be measured here. One must keep in mind that evaluation may be influenced by difficulties in measurement, attribution, contamination and proliferation of the process. In this case, knowledge, attitudes and quality of life are difficult to measure, and so outcome evaluation should be based more on assessment of the following *direct measures*:

- behaviour: population and target surveys of smoking status;
- health status: of smoking-related diseases;
- mortality: from smoking-related diseases.

However, to assess the short-term impact, easy-to-measure performance indicators can also be used as *proxy measures*:

- sales of tobacco and smoking-cessation pharmaceuticals;
- participation rates in 'Quit & Win' campaigns and applications for smoking cessation clinics.

CONCLUSION

Health promotion can be attained only by the assessment of health needs, and their subsequent satisfaction through the necessary strategic initiatives. The tightening of tobacco legislation is a prime example of health promotion not being the responsibility of just the health sector, but of going "beyond lifestyles to well-being", as the Ottawa Charter for Health Promotion concludes[1].

Thus, tobacco control must be not merely a top public health priority, but a top public policy priority with the government playing a central and crucial role[4]. Among the resolutions approved at the conclusion of the 11th World Conference on Tobacco or Health in Chicago, U.S.A. during August 2000, was the recommendation that all national health ministries have full-time staff charged with overall responsibility for ensuring sustained tobacco control programmes[39]. Members of the U.K. House of Commons health committee have also recommended the creation of a tobacco regulatory authority[40]. In fact, the setting-up of a coordinating tobacco control authority has been emphasised as a priority for Malta. Such authority must be given the mandate to manage all efforts required to stem the tobacco epidemic, not least the coordination of the different activities existing today to avoid duplication and increase effectiveness[41].

Malta was one of the signatories of the 2002 Warsaw Declaration for a Tobacco-free Europe, which committed participating countries to the effective implementation of comprehensive policies with measurable impact on the reduction of tobacco use[42]. These include high taxes, bans on tobacco advertising, sponsorship and promotion, protection against involuntary exposure to environmental tobacco smoke in public places and workplaces, access to cessation measures and strict control on smuggling. As declared by Sir George Young, a British health minister who understood the politics of tobacco: "The solution to many of today's medical problems will not be found in the research departments of our hospitals, but in Parliament. For the prospective patient, the answer may not be incision at the operating table, but prevention by decision at the cabinet table."[28]

It is augured that the Maltese government will heed these wise words through supporting and implementing the development, monitoring and evaluation of national health promotion policies in general, and this initiative on smoking in particular.

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An Anthrax Epidemic in the Maltese Islands

C. Savona - Ventura
Medical Historian

Bacillus anthracis has during 2001 hit the international headlines through its use in the U.S.A. by terrorists. The bacillum, which causes the disease known as Anthrax, is an excellent weapon to the terrorist's criminal mind since the micro-organism is particularly resistant to environmental changes, withstanding dry heat, and persisting for years in dry earth. Since the infection has become a rare entity in most developed countries, an outbreak of cases particularly in low risk individuals is easily identified with terrorist action. The uncertainty arising from any terrorist action, together with the fear of being exposed to a potentially lethal infection, easily results in fear, alarm and panic in the developed world thus achieving the terrorist's primary scope.

Anthrax has afflicted humans throughout recorded history. The fifth and sixth plagues of Egypt described in Exodus are widely believed to have been anthrax. The disease was featured in the writings of Virgil in 25 BC and was familiar in medieval times as the Black Bane. It was from studies on anthrax that Koch established his famous postulates in 1876, and vaccines against anthrax, the best known being that of Pasteur (1881), were among the first bacterial vaccines developed. Anthrax remains a relatively common infection in the undeveloped world. It is primarily a disease of sheep, cattle, horses and many other animals; humans are affected only rarely. The infection in humans is usually acquired by the entry of the bacillum spores through injured skin or mucous membranes giving rise to cutaneous anthrax. Rarely, the inhalation anthrax or woolsorter's disease may occur after inhalation of the spores into the lungs. Ingestion of spores in the gastrointestinal tract can give rise to the rare form of intestinal anthrax infection. Careful control of animal herds in the developed world has in general been effective in reducing the cases of anthrax seen in animals and subsequently in man. In the Maltese Islands also, careful screening of imported herds throughout the 20th century by the Veterinary Department has helped prevent the disease from becoming endemic and affecting local herds.

Anthrax infection was never a notifiable disease and hence no records exist regarding its incidence through the decades. It was however a notifiable cause of death. The Veterinary Department, falling under the overall direction of the Department of Health in the early decades of the 20th century, further recorded cases seen in local and imported animal herds. The published annual reports of the Department of Health since 1896 thus serve to give a general picture of the pattern of this disease on the Maltese Islands. These reports record seven human cases that terminated in a death. The first five cases occurred in the late 19th century (Table 1), while the last case occurred in July 1915. There is unfortunately no published data about animal anthrax infections during the 19th century which can be related to whether the disease noted through the recorded human deaths was endemic or imported from overseas. The 1915 death was possibly associated with the importation of infected cattle, though the closest identified cases of animal Anthrax occurred in a cargo of Tunisian cattle. The animal was destroyed in the Government Incinerator.

Throughout the first half of the twentieth century, imported herds of animals were repeatedly found to be infected with

Year	No. of human deaths	Comments
August 1895	2	1 female aged 55-64 years from Sliema
October 1895		1 female aged 65-74 years from Valletta
1896	1	1 individual aged 15-19 years.
1897	2	2 individuals aged 25-34 & 65-74 years.
July 1915	1	1 male aged 65-74 years.

Table 1: Human Deaths caused by Anthrax in Malta

Year	Infected Cargoes	Destroyed animals
1900	• 1 cargo of cattle from Tangier • 1 cargo of cattle from Benghazi	• 4 carcasses destroyed originating from Ras Hanzir (2) and Lazaretto (2)
1902	• 3 cattle cargoes from Tunis	• see Table 3
1903-04	• 1 cattle cargo from Salonica	• 10 carcasses destroyed originating from the Lazaretto
1908-09	• 2 cattle cargoes from Salonica	• 6 carcasses destroyed: 2 from Qormi district, 1 from the Lazaretto, and 2 from on board ships
1909-10		• 1 carcass destroyed originating from the Tarxien-Paola-Luqa-Gudia district
1911-12	• One case in a bullock imported from Salonica	• 1 carcass destroyed originating from the Msida-Pieta district
1914-15	• One case in cargo of Tunisian Cattle	• 2 carcasses destroyed originating from the Msida-Pieta district and on board ship
1918-19	• 1 cargo of cattle imported from Tunisia; herd kept in quarantine	• 2 carcasses destroyed originating from the Tarxien-Paola-Luqa-Gudia district

Table 2: Animal Anthrax cases first two decades of 20th century

Anthrax. These were regularly checked by the Government Veterinary Surgeon, and were subsequently destroyed by incineration. Solitary cases also occasionally occurred in local herds, these being similarly destroyed by incineration (Table 2). There was apparently only one instance (1901-1902) when the infection took on epidemic proportions affecting local animals.

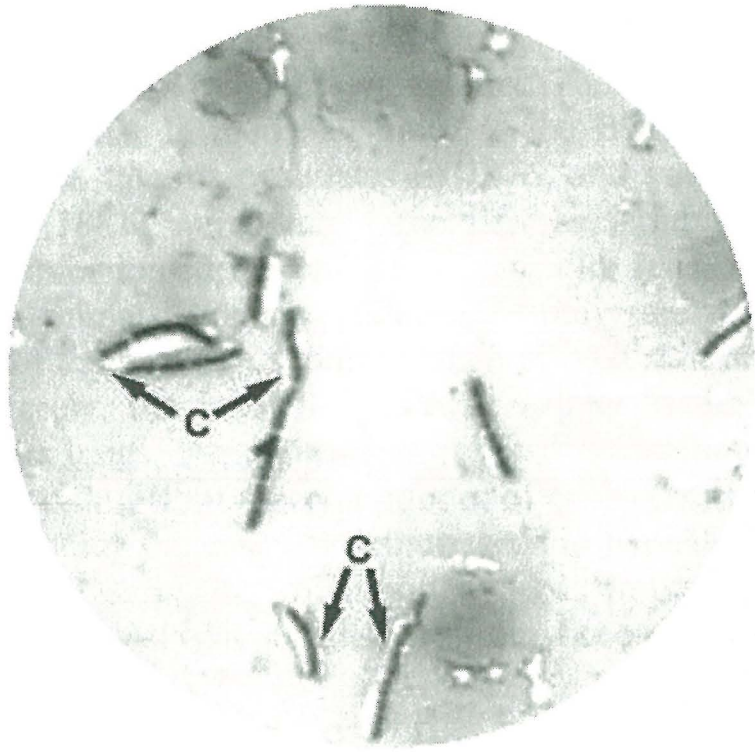
This epidemic came to the attention of the authorities in October 1901. By the end of that year no less than 49 cases of dead animals were proved to have died from the infection. The cases occurred cont-emporaneously in widely separated districts in Malta. This led to the suspicion that the epidemic was probably due to a common cause that was attributed later on to contaminated food. All the possible precautions were taken to prevent the spread of the disease. The carcasses were carted in a specially built contrivance to be destroyed by fire in a temporary incinerator built for the purpose. All infected pens were thoroughly disinfected, and all other contact animals kept in isolation for seven days. In spite of all these efforts, the infection spread to the sister island of Gozo though only four cases were recorded there during 1901. Because of the lack of an incinerator in this island, disposal of infected carcasses was carried out by sprinkling with petroleum and setting fire to the carcass. The ashes were afterwards buried. Those carcasses that could not be burnt were buried 6-feet deep after being thoroughly disinfected. In the subsequent three months - Jan-March 1902 - fifty further cases of Anthrax were identified affecting various animals including equines (9 cases), bovines (12 cases), ovines (16 cases) and swine (13 cases). The infection persisted until the 6th October 1902. By this time, a total of 138 carcasses had been incinerated (Table 3). In spite of the epidemic proportion of this outbreak, no cases of Anthrax were recorded in humans.

REGION	No. of cases
• Inner Harbour Region	15
• Outer Harbour Region	30
• South Eastern Region	24
• Western Region	30
• Northern Region	21
• Lazaretto & on board ships	18

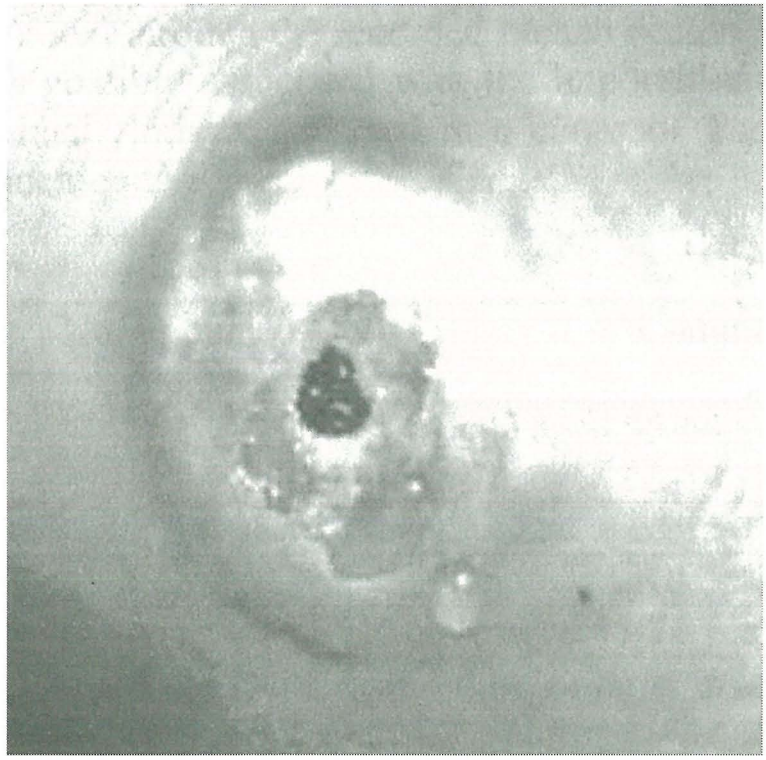
Table 3: Incinerated carcasses during 1901-02 Anthrax epidemic

The problem of inadvertently introducing Anthrax in local herds was taken very seriously by the local health and veterinary authorities. Careful control of all imported animals was carried out and any animals found to be infected were destroyed by incineration. This control was extended occasionally also to imported products made from animal fur. Thus in 1943, a consignment of shaving brushes imported from Japan were tested by the Public Health Laboratory for the possibility of contamination by Anthrax. In the natural state, the infection is relatively easy to control. Not only is the bacillum very susceptible to commonly used antibiotics, but also active immunity to anthrax can be induced in susceptible animals or persons by vaccination with live attenuated bacilli, with spore suspensions, or with protective antigens from culture filtrates. Anthrax immunisation is based on the classical experiments of

Louis Pasteur carried out in 1881. When used by terrorists, the disease is more difficult to control since no high risk group is identifiable for prophylactic vaccination. Treatment is fortunately still effective when instituted early enough.



Anthrax bacillum



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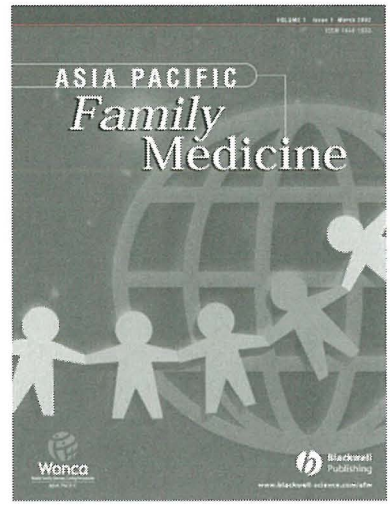

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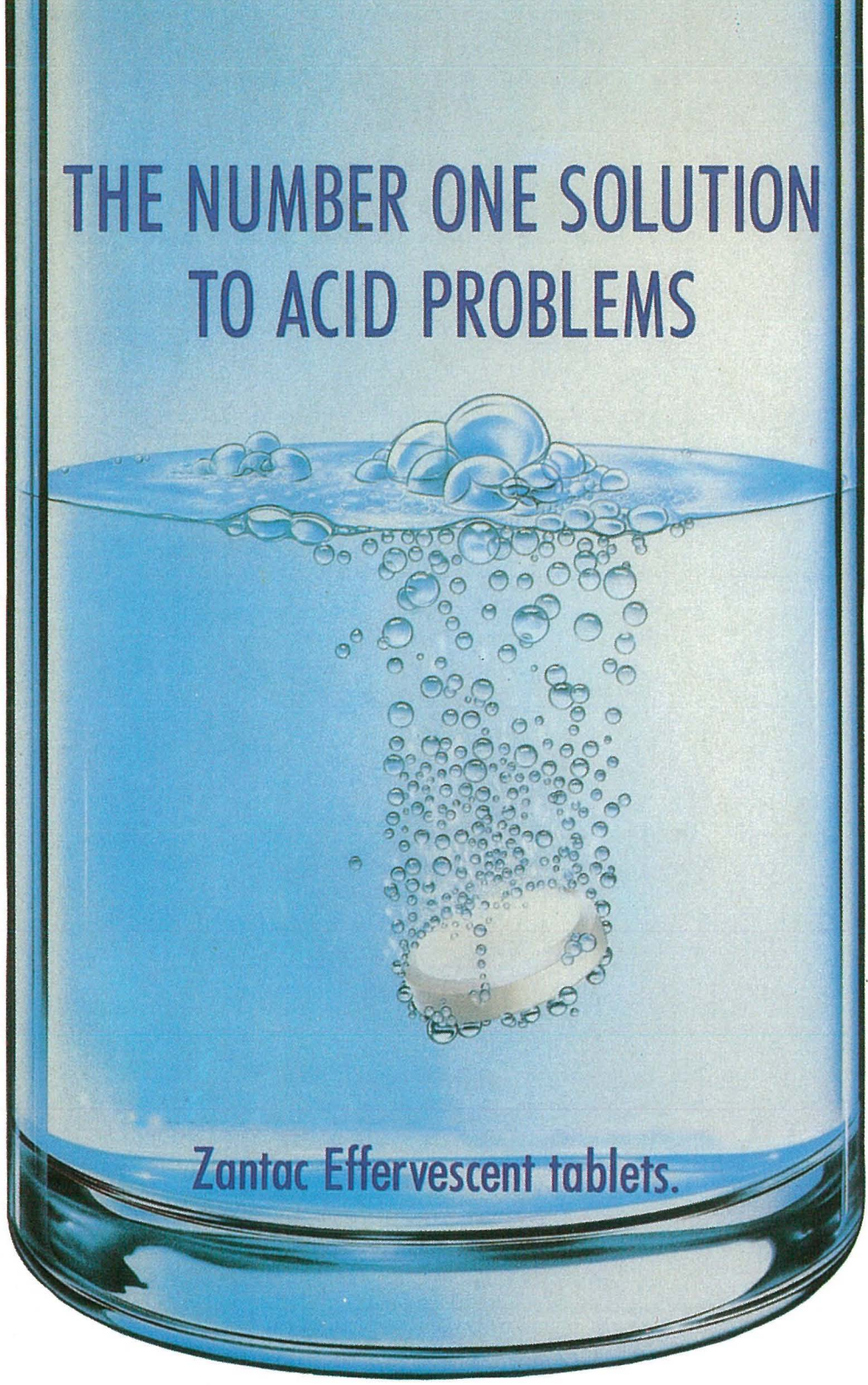

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GETTING TO GRIPS WITH URTICARIA

L. SCERRI
DERMATOLOGIST

INTRODUCTION

Urticaria is indeed a common dermatological affliction, which imparts a considerable degree of distress on the sufferer. Its clinical spectrum comprises *urticarial weals* (superficial dermal swellings), *angio-oedema* (deeper swellings), and the dreaded but fortunately rare *anaphylaxis*. Acute urticaria (lasting up to 6 weeks) is commoner in children, whereas chronic urticaria (which lasts anything from 6 weeks to several years) is commoner in adults. The underlying key patho-physiological event is the degranulation of mast cells and basophils, leading to the release of multiple mediators, the most important of which being histamine. Cellular degranulation may be triggered off either via an immunulogical process (IgE mediated) or directly (non-immunological). The released histamine binds to cutaneous histamine receptors producing the swelling, erythema, and itch. The aim of treatment is simply to suppress the symptoms until the disease process burns out.

CLINICAL FEATURES AND VARIANTS OF URTICARIA

Ordinary urticaria typically consists of recurrent waves of itchy urticarial weals, with or without angio-oedema of the lips and/or eyelids, with each lesion lasting less than 24 hours. In the vast majority of cases, no cause is elicited, and routine blood investigations are not usually helpful[1].

Food allergy is an uncommon cause of acute ordinary urticaria. This may be suspected when there is a convincing history of an acute urticarial flare up within an hour of ingesting a particular dietary item. Such allergies may be confirmed by performing skin prick tests or a specific IgE RAST blood screen[2]. Drug allergy is another cause of acute urticaria. Contact urticaria / anaphylaxis may result from latex exposure in sensitized individuals. Patients with established food (e.g. peanuts) or latex allergy should carry around a 'life-saving' adrenaline auto-injection (Epi pen) at all times in case of emergencies. It is worth bearing in mind that threadworm infestation in children may sometimes present with urticaria. Indeed, any parasitic infestation, including scabies, may give rise to an urticarial rash as part of the clinical picture, and a high blood eosinophil count is usually present.

Physical urticaria refers to an urticarial reaction in response to a physical stimulus. The most common, and often underdiagnosed physical urticarias are (a) symptomatic dermographism – linear wealing on stroking or scratching the skin[3], and (b) cholinergic urticaria – widespread pinpoint urticarial papules in response to overheating and sweating such as after exertion or being in a warm environment[4]. An attack of physical urticaria normally subsides within one hour. Physical urticarias may present in isolation or may sometimes co-exist with ordinary urticaria. The only investigation indicated for suspected physical urticaria is a 'challenge test' in order to reproduce the urticarial eruption such as (a) testing for dermographism by stroking the back with the rounded edge of a wooden spatula, and (b) getting the patient to jog on the spot for a few minutes in case of suspected cholinergic urticaria.

Urticarial vasculitis is a rare distinct form of urticaria, which is clinically distinguished by the fact that weals last for several days, and the lesions often demonstrate a petechial element. A skin biopsy will reveal a vasculitic histology, and patients tend to have an elevated ESR and low serum complement. This disease entity is complement-mediated and hence does not respond to anti-histamines.

Another distinct form of urticaria, which does not respond to anti-histamines, is *angio-oedema of C1 Esterase deficiency* (most commonly heredetary). Patients with this chronic condition complain of recurrent angio-oedematous swellings without urticarial weals, and may effect both skin and mucous membranes. Patients should be warned that potentially fatal laryngeal oedema is a possible complication, which does not respond to adrenaline and corticosteroids. Long term prophylaxis is with androgens or anti-fibrinolytics, and short-term peri-operative prophylaxis or emergency treatment is with fresh frozen plasma or C1 Esterase inhibitor concentrate.

TREATMENT

The mainstay of treatment for ordinary and physical urticarias is anti-histamine therapy. A non-sedating H1 antagonist (loratadine, fexofenadine) or minimally sedating H1 antagonist (cetirizine) is usually sufficient to control most cases of ordinary and physical urticaria[5]. The dose may however need to be increased over and above the standard dose in order to achieve a clinical response. The addition of a

sedating anti-histamine or tricyclic antidepressant at night can prove helpful if sleep is severely disturbed. In refractory cases, the addition of an H2 antagonist (ranitidine, cimetidine) to the H1 antagonist may give superior results. It is worth noting that in patients with chronic urticaria, long term continuous prophylactic therapy confers a better quality of life than intermittent on-demand therapy. As a rule, systemic corticosteroids should be avoided in ordinary and physical urticaria as it will be very difficult to tail them off without a severe rebound of the urticaria. The only exceptions to this rule are severe allergic acute urticaria/angio-oedema, and anaphylaxis. Furthermore, topical steroids are not recommended in view of the migratory nature of the urticarial lesions.

Apart from prescribing drug treatment, patients should be advised on avoiding certain non-specific aggravating factors. These include aspirin, NSAID's, codeine, alcohol, overheating and stress! Finally, a 3-week trial of a diet free from additives (preservatives and colouring agents), which involves avoiding packed and tinned food, and limiting drinking to non-fizzy mineral water, may be worth trying in refractory cases.

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The Opinion of Family Physicians on Their Working Conditions in the Turkish Health Care System

A. Uğur
Family Doctor, Turkey

In Turkey, family practice residency programs have run since 1985 and there are approximately 800 family physicians and 400 residents today. Family physicians work either in the public or private sectors, but the relative percentages are uncertain. In the public sector they are mostly detailed to the Health Centres, Centres for Mother and Child Care and Family Planning, inpatient health care centres, hospitals of the Turkish Ministry of Health and the health care centres of the other ministries (1). There is not sufficient information about the working conditions of family physicians in Turkey (2). There is a need for qualified primary health care physicians in Turkey, but on the other hand, family physicians are seeking a more appropriate working environment.

The aim of this preliminary report was to assess the expectations of Turkish family physicians concerning appropriate working environment. It is difficult to perform a satisfactory sampling to represent all the family physicians in Turkey. Therefore it was decided to perform this study during the 4th National Family Physicians Congress 1999, Istanbul. Two hundred eighteen specialists and residents in family medicine participated in the congress. All of them were asked to participate in this survey. The questionnaires of 58 specialists and 38 residents which were fully completed have been included in the study (response rate 44%). The participants were asked to fill a questionnaire with 12 close ended questions (having "other" choice in the answers) which contained questions on sociodemographics, working experiments, appropriate working conditions for family physicians and the preferable properties of working conditions.

The data was evaluated with the chi-square method. The significance level has been set at 0.05.

The mean post graduate period after the medical faculty for the residents was 5,7 years with 3,1 minimum and 8,4 maximum. The mean postgraduate period for the specialists was 10,6 with 7,5 minimum and 13,7 maximum. Seventy six percent of the specialists and 63% of the residents had experience in the private sector.

Thirty six percent of the specialists and 76.3% of the residents identified their most work satisfaction during residentship. The specialists further mentioned they were satisfied during their work in private sector (19%), and governmental posts (10.3%). Residents revealed governmental health centres (10.5%) and private sector (5%) as satisfactory work periods.

The most appropriate working places for a family physician in Turkey emphasised by specialists were private offices (28%), government inpatient health clinics of (16%), ACSAP (12%) while residents identified private offices (21%), government inpatient health clinics (16%),government hospitals (13%) and private insurance companies (10%). When family physicians were asked about ideal working places specialists and residents made similar choices, but specialists preferred to work in private offices more than the residents. This difference must have been influenced by the fact that residents are not permitted to work in private offices(1).

	Specialists (n=58) %	Residents (n=38) %	p	X^2
Private offices	64	42	<0.05	4.37
Private insurance company	52	66	>0.05	
ACSAP	48	60		
Inpatient health clinic	47	39		
Government hospital	19	45	<0.01	7.38
In house physician	43	37	>0.05	
Occupational medicine	38	63		
Training staff in universities	36	42		
Official health care units	33	18		
Health care units of the universities	21	34		
Travellers medicine	24	24		
Health administrator	14	16		
Family practice centre	10	8		

Table1: Opinions of the participants about the most appropriate working places for a family physician in Turkey. (When their top five choices are counted)

An interesting finding is that preference of the private sector is among the first two choices of an ideal working environment, by both specialists and also residents. Other studies have shown that, besides the desire to become a family physician, medical doctors also prefer to live in big cities once they have passed a speciality examination. The physicians in our study also preferred to work in big cities, while on the other hand the Ministry of Health employs them in the rural districts. Resignation from the government service to work in the private sector is often the outcome of the difficulty in obtaining official appointments in the big cities (3).

Family physicians with these expectations do not find that the services performed in the Health Centres, Centres for Mother and Child Care and Family Planning are compatible with the concepts of family practice. Ninety three percent of these cannot practice family practice and 7% are not able to practice any clinical science. The ones working in government hospitals have problems with physicians from other specialities regarding management issues, duties and responsibilities. The most important problem is the lack of opportunities to apply the knowledge learned during the residency program(1,4).

In conclusion, 84% of family physicians are not satisfied with their existing medical conditions. Turkish family physicians are looking for a frame of work more commensurate with their past occupational experience, the clinical skills they developed in the residency program and their accumulated knowledge about family practice (in Turkey and in other countries). On the other hand, most of them prefer to live in big cities. With some changes in the regulations, the shift to the private sector would be prevented. Additionally it may be possible to incorporate the private sector health care organisations into the government health care system (3).

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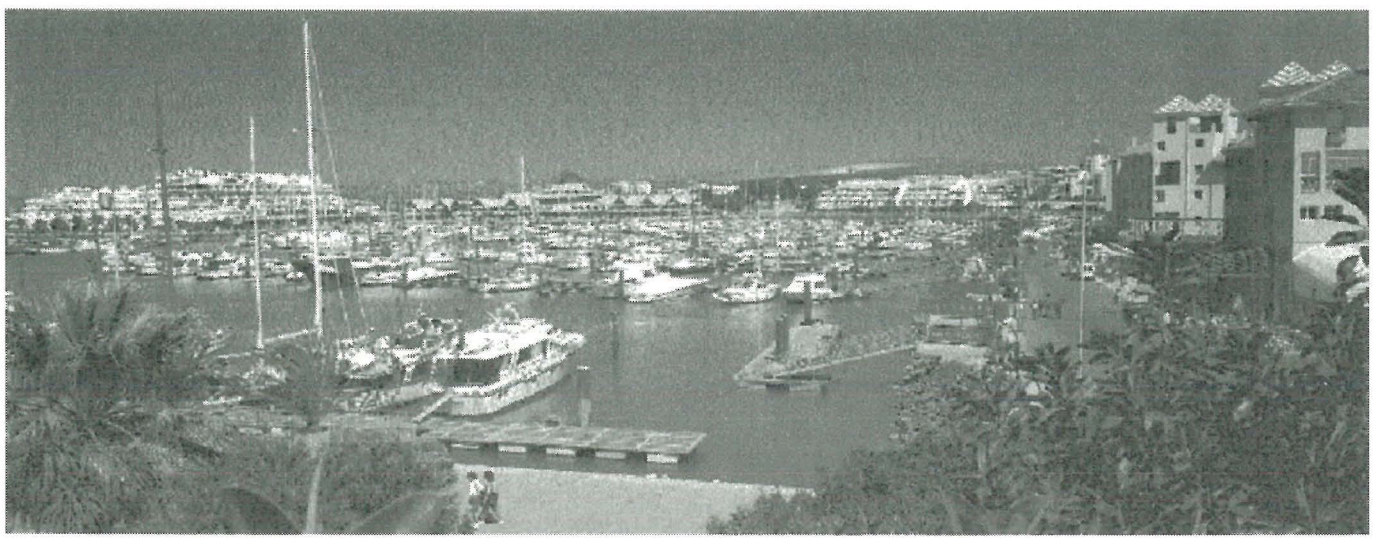

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Letters to the Editor

A Lesson Worth Learning

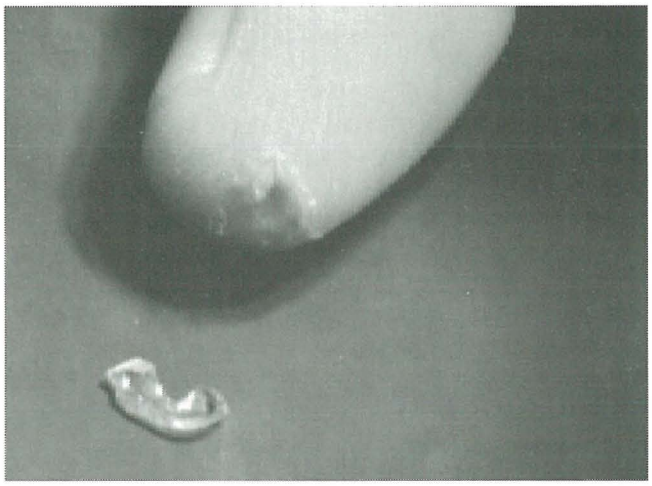
Hermann Karl Borg
ENT Surgeon

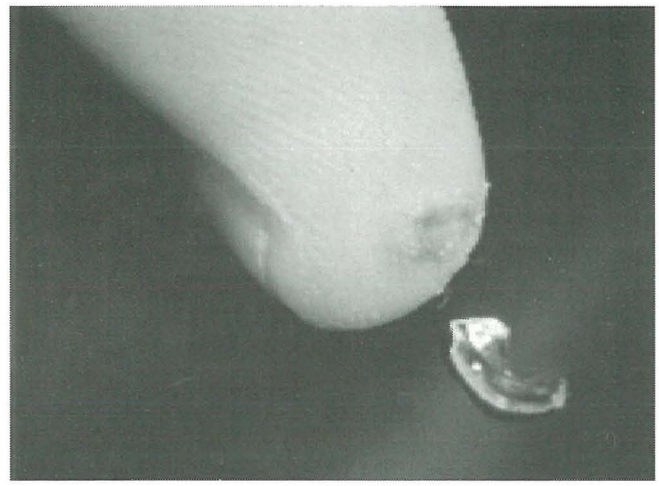
A twenty-four year old houseman complained of shooting pains in his right thumb making it very uncomfortable to perform tasks.

Three weeks earlier, during a very busy on-call, he had opened a glass drug phial with his bare hands, cutting his thumb in the process. He applied a plaster to the very small wound; this resulted in complete healing. At the time of presentation, exploration under local anaesthesia revealed the offending piece of glass with complete cessation of the shooting pains.

This case underlines the importance of using basic safety measures when dealing with all sharps at work.

Hermann Karl Borg





Reference to Article in June 2001 Issue

Pierre Mallia
Family Doctor

Dear Readers,

I would like to apologize for a mistake appearing in my article. Advanced Diective should read Advance Directive. This typing error on my part appears through the article.

May I take this opportunity to comment on your editorial. Indeed there is much we can do in Family Medicine together to increase our status. As Family Doctors we must not only pay lip service to ideas of research, Patient Registration and increasing our status to a body of learned individuals, but we should also be patient advocates. For this reason we must resist temptation to be undermined and that we are some inferior breed of doctors. We can learn considerably from our specialist colleagues, but given the opportunity they in turn can learn a lot from us, as happens in the rest of the world. Being autocritical is healthy; being autoskeptical is not. Sometimes we are our own worst enemies.

But respect is earned. Doing research in our communities, even modest ones as you clearly point out, is an obligation we have as patient advocates. People, including the rest of the profession, will judge us by our fruit. This journal is one of the main trees on which that fruit grows.

Maybe we could bargain with the government to financially fund research projects by GPs. But even without funds, there is a lot that we can do.

Yours sincerely,
Pierre Mallia

Correspondence and contributions to this journal are to be sent to:
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•A.B.S • 5 SPEED GEARBOX • REAR WIPER • IMMOBILIZER • TINTED GLASS
• AIRCONDITIONER • POWER STEERING • CENTRAL LOCKING • 3 INDIVIDUAL REAR SEATS
• ELECTRIC FRONT WINDOWS • RADIO CASSETTE • FRONT & REAR HEADRESTS
• ERGONOMIC DRIVER'S SEAT • ELECTRICALLY OPERATED DOOR MIRRORS • ADJUSTABLE STEERING • 4 AIRBAGS

RENAULT

AUTO SALES LIMITED

Mosta Road, Lija.
Tel: 433601/2/3
Msida Road, Gzira.
Tel: 33031

Il-pjan ta' tfaddil li jaħdem għalik!

Qed taħseb biex twarrab xi ftit flus għal xi ħaġa speċjali jew biex isserraħ moħħok f'każ ta' bżonn?

Meta tibda tfaddal, huwa xieraq li tfittex l-aħjar mod kif iżżid il-flus li tkun qed twarrab.

Għalhekk jekk għandek il-ħsieb li tfaddal biex issiefer, biex tixtri xi apparat tal-*Hi-Fi*, xi ħaga għad-dar tiegħek jew inkella għall-kontribuzzjoni ta' self, il-*BOV Savings Plan* jgħinek tilħaq l-għan tiegħek.

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