In this CPD issue:

The CPD section of this issue of the SA Family Practice journal starts with the sixth in the series on healthy lifestyle interventions in general practice. This article focuses on "Lifestyle and metabolic syndrome" by Schwellnus MP *et al.* They indicate upfront that there is no clarity on the precise definition of the metabolic syndrome but there is consensus that it is a cluster of inter-related risks factors namely elevated blood pressure, elevated plasma glucose and atherogenic dyslipidemia, due to mainly abdominal obesity and insulin resistance. In the article, the authors further explain that the prevalence of metabolic syndrome is increasing globally with its prevalence in developed countries about 30% in the adult population. In the South African population, the prevalence of the syndrome is not known as national prevalence surveys have not been done. But prevalence studies on obesity point in the direction of increasing numbers of men and women who are over weight or obese. In terms of management, lifestyle intervention is consistently regarded as the first line treatment and the cornerstone of management. This includes nutritional intervention, promotion of physical activity, psychosocial care and education. The article has practical strategies on how to implement the lifestyle intervention and ends with the importance of follow up assessment to re-set goals for achievable outcomes in the patient.

The article on spontaneous pneumothorax by Mpe MJ highlights a usually forgotten form of pneumothorax which is relatively common amongst cigarette smokers (12% life time risk). He explains the difference between primary and secondary spontaneous pneumothoraces, indicating the presence of sub-pleural blebs and bullae in up to 90% of cases at thoracoscopy despite the absence of underlying pulmonary disease. The clinical presentation and diagnosis are concisely presented with the range of treatment modalities explained from 'observation to open thoracotomy' depending on the severity of the condition. But simple aspiration is still recommended as first line treatment for all primary spontaneous pneumothoraces which require intervention. For recurrent spontaneous pneumothoraces which are commoner in smokers, counseling against flying until a follow-up chest x-ray confirms resolution of the pneumothorax is advocated.

Porphyria cutanea tarda (PCT) which is the most common type of porphyria in South Africa is presented by Motswaledi MH due to its increasing incidence amongst HIV positive patients. The fundamental abnormality is a reduction or deficiency of the hepatic enzyme uro-porphyrinogen decarboxylase, with 80% of cases being sporadic and 20% familial in aetiology. Although one of the causes of sporadic PCT is hepatitis C viral infection, the latter is a relatively rare cause of PCT in the South African population. The condition presents with blisters on friction areas, sun-exposed parts of the body which heal with atrophic depigmented scars. The management includes sun protection and avoidance, and symptomatic treatments of the blisters. Chloroquine may be prescribed as it binds to porphyrins and assists with their excretion. Erythropoietin (bone marrow stimulant) may be helpful in those with PCT who are also anaemic.

The diagnostic approach to common arthritic conditions by Tikly M covers the diagnosis of various types of arthritis from a primary care point of view. He stresses the fact that arthritis is a common cause of pain and disability in adults and concisely discusses a simple step-by-step approach to salient clinical and diagnostic issues in differentiating the various types of arthritis. Advocacy for appropriate investigations is also discussed including the full blood count as a useful screening test to confirm or rule out septic arthritis from the other types of arthritis. Anemia of chronic disorder is seen to be common in arthritis but can also result from iron deficiency secondary to NSAID-induced peptic ulcer disease. The review of the specific in-depth management approach of the various types of arthritis will be covered in a subsequent article.

The ethics article by Knapp van Bogaert D and Ogunbanjo GA discusses the difference between confidentiality and privacy. Confidentiality is linked to the value of trust in doctor-patient relations. In this encounter, a patient communicates to the doctor particular information which is of a personal nature. The patient expects that the doctor will, as bearer of this trust, not divulge that information to a third party without the confider's permission. On the other hand, privacy is a term used in tort law involving two things - control over some information about us, and some control over who can experience us or observe us. Although a person's right to privacy is not considered a natural right, it always concerns relationships between agents. The article gives an example to highlight the intricacies of the two terms and will appreciate the opinions of readers on the case. As I end this editorial, comments on the content and topics presented in the CPD section of the journal will be appreciated.

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