In this CPD issue

The choice of continuing professional development (CPD) articles in this issue is diverse, but they are all common conditions encountered by family practitioners from time to time.

The first article on *Burning mouth syndrome* (BMS), by WFP van Heerden, describes a poorly understood chronic condition characterised by dryness of the mouth, alteration of salivary components, as well as taste disturbances, which may present with a burning sensation of the tongue similar to that experienced by a hot drink. It is most prevalent in postmenopausal women, with a prevalence rate in the general population varying between 0.7-15%. Diagnosis is based on the absence of visible oral lesions, and is hence a diagnosis of exclusion. The management of BMS is symptomatic. Patients are reassured that the symptoms are not linked to an undiagnosed cancer. Spontaneous resolution occurs in about 60% of patients after six to seven years. Topical agents such as low-dose clonazepam (0.25 mg/day), and/or systemic alpha lipoic acid or selective serotonin reuptake inhibitors, have proved to be effective in controlled, double-blind studies.

The second article, *Familial hypercholesterolemia* by DJ Blom, comprehensively covers this condition. Familial hypercholesterolemia (FH) is the most common monogenic disorder of low-density lipoprotein (LDL) characterised by markedly elevated LDL cholesterol, autosomal dominant inheritance, premature cardiovascular disease and tendon xanthomata. In South Africa, the founder effects of FH are in three populations, that is, White South Africans of Afrikaner descent, Jewish South Africans of Lithuanian descent, and Indian South Africans of Gujerati descent. The diagnosis is clinical, using genetic testing to identify the causal gene. The article describes FH phenotypes, genes linked to FH and clinical genetics of the syndrome. Of interest are some misconceptions about the genetics of FH, which the author addresses. A detailed family history is important to establish the inheritance pattern of hyperlipidaemia, plus a family genogram. The management of FH covers the individual to reduce cardiovascular risk and the family at risk. Pharmacologically, statins are the lipid-lowering drugs of choice, with Ezetimibe (a cholesterol absorption inhibitor) added as an adjuvant. Bile acid sequestrants (BAS) have a limited role due to their poor tolerability. Fibrates and nicotinic acid are indicated for carefully selected patients with additional lipid abnormalities, such as high triglycerides or low high-density lipoprotein cholesterol (HDLC).

The third article is on *Sports injuries in adults: overview of clinical examination and management,* by DC Janse van Rensburg and K Nolte. The overview covers acute and chronic injuries in adults, the approach to diagnosis and management strategies. Acute sport injuries occur from a single, well-defined incident, while chronic injuries follow an accumulation of micro trauma to bone, cartilage, ligaments, tendon or muscles. They indicate that in sports, tendon injuries are among the most common overuse injuries, and it is important to distinguish between paratenonitis, tendinosis and tendonitis. Detailed history of the injury, coupled with examination of the injured area, is essential. Available investigations include X-rays, an MRI, a CT-scan and electromyography. The gold standard of initial sports injury treatment follows the mnemonic, RICE (relative rest, ice, compression and elevation). Drug treatment includes analgesics, nonsteroidal anti-inflammatories (NSAIDs) and corticosteroids. Available novel therapies under discussion include prolotherapy, sclerotherapy, topical glyceryl trinitrate and platelet-rich plasma (PRP) injections.

The last article is on *Healthy lifestyle interventions in general practice, Part 13: Lifestyle and osteoporosis* by MP Schwellnus et al. The condition is a systemic skeletal disease characterised by low bone mass and microarchitectural deterioration of bone tissue. The article covers diagnosis and classification, based on two criteria, namely bone mineral density and evidence of a fragility fracture. Reliable data on the prevalence of osteoporosis in South Africa are unavailable. This article covers lifestyle interventions for the prevention and management of osteoporosis, namely physical activity, nutritional factors, psychosocial factors and smoking cessation. Physical activity increases bone mineral accrual in children and adolescents. Calcium and vitamin D are essential minerals involved in bone formation. Other crucial nutritional factors are phosphate, magnesium, potassium, sodium, vitamins A, C and K, and trace minerals. The authors also identify nutritional lifestyle considerations that can negatively affect bone health, such as vegetarian diets low in calcium and excessive alcohol and caffeine intake. Caffeine intake more than 400 mg per day (four cups of coffee) is excessive. The table on the average quantity of caffeine in selected beverages is worth noting. The authors offer practical recommendations for optimising nutritional lifestyle interventions for bone health. For fall prevention programmes, they conclude that there is little evidence for a rational approach to fall prevention, over and above “educating” the patients at risk.

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