

In this CPD issue



This edition of the *SAFP* features five CPD articles, which I hope will add some new knowledge that may influence your practice. In the first, *Lifestyle and obesity* by EW Derman et al, obesity is defined as an excessive amount of body fat or adiposity, which is measured by the body mass index. There is ample evidence that obesity is clinically associated with a variety of chronic diseases and medical conditions, such

as coronary artery disease. The authors stress that obesity is a global phenomenon and that, in South Africa, an estimated 29% of adult men and 56% of adult women are overweight or obese. To stem this tide, the management of obesity must be multi-faceted, involving the combined lifestyle interventions of regular physical activity and dietary and psychological measures. The benefits of regular physical exercise in obese patients include improved insulin sensitivity, favourable changes in metabolic rate, lipid profile, blood pressure and inflammatory markers, and an overall improvement in co-morbidity risk. The psychological treatment of obesity includes psychotherapy for binge eating, the management of co-morbid psychiatric disorders such as depression, behavioural programmes that address adherence to a healthy eating plan, and coping skills to manage relapse. The article covers the role of commercial weight loss or self-help programmes, and stresses that the evidence to support the majority of commercial and self-help weight loss programmes is lacking. The authors conclude that general practitioners should be aware of the benefits of exercise and healthy nutritional and psychological interventions, and that they should assist their patients by suggesting adherence to accepted physical activity and nutritional guidelines.

It is a fact that cardiovascular disease remains the leading cause of mortality in the Westernised world. Various interventions reduce cardiovascular risk, and these include lifestyle changes and drug therapy. *Cardiovascular risk assessment* by DJ Blom attempts to provide some insight on this practice tool, which can be used to determine absolute cardiovascular risk in asymptomatic patients and to select those most likely to benefit from intervention. The author discusses conventional risk assessment, of which the Framingham algorithm is the best-known risk-assessment tool. Other risk scores include the European SCORE project, the PROCAM Score and the QRisk score, to mention a few. Most risk-assessment tools report the absolute 10-year risk. The author alludes to the fact that there are problems with risk assessment, covered under prevention strategies, epidemiology, statistical issues, clinical issues, expanded risk assessment and additional blood tests. He concludes that routine clinical risk assessment is best done with conventional risk algorithms, and that additional tests may be helpful when the risk is borderline or when "unusual" risk factors are present.

The article on *Hypertensive disorders in pregnancy* by J Moodley reminds us about the importance of being vigilant in detecting and appropriately managing this most common direct cause of maternal morbidity in South Africa. Hypertension in pregnancy is defined as blood pressure measurements > 140 mmHg systolic and ≥ 90 mmHg diastolic, taken on two occasions, two to four hours apart.

The author stresses that, in the referral criteria for the management of patients with moderate to severe pre-eclampsia (blood pressure ≥ 150/100 mmHg), the logical option is to direct such patients to either a regional or a tertiary hospital, where management would be optimal. Cerebrovascular accident is still the most common cause of maternal death associated with pre-eclampsia. Hence, it is prudent to use rapid-acting antihypertensive agents promptly, aiming for a gradual and sustained lowering of elevated blood pressure. The author suggests the prescription of nifedipine 10 mg orally by general practitioners for acute lowering of high blood pressure in young pregnant women who have symptoms of imminent eclampsia before referral to the next appropriate level of care. The role of methyl dopa in pregnancy, the cessation of diuretics because of their negative impact on the increased plasma volume during pregnancy, and awareness that patients with a previous history of hypertensive disorders of pregnancy have a 20% chance of having early-onset pre-eclampsia in subsequent pregnancies are also discussed in the article.

Attention-deficit hyperactivity disorder in adults by GI van Schalkwyk and J Schronen deals with a condition of which knowledge on the diagnosis and treatment remain limited amongst general practitioners. ADHD is thought to affect only children, but data suggest that more than 60% of childhood ADHD cases continue partially into adulthood. The global estimated prevalence of adult ADHD is 3.5%. The clinical presentation is variable, and the manifestations of the characteristic symptoms of inattention, hyperactivity and impulsivity are different in adults. The author compares the symptoms of ADHD in children and adults, which provides some direction on how to diagnose this condition in adults. The stimulant methylphenidate remains the drug of choice, although it has less consistent success rate in adults as opposed to children. In adults with ADHD who cannot be administered stimulants due to a drug addiction, the second-line medications include atomoxetine and the antidepressants venlafaxine and bupropion, although efficacy is not well documented.

The article by MH Motswaledi addresses *Superficial skin infections and the use of topical and systemic antibiotics in general practice*. The author discusses the diagnostic features of common superficial skin infections and their management in a simplified manner. These include impetigo, ecthyma, erysipelas, cellulitis, furuncles and carbuncles, and staphylococcal scalded skin syndrome., and are common in childhood. The conditions are usually caused by *Staphylococcus aureus* or streptococci. *Haemophilus influenzae* type b is an important cause of facial cellulitis in young children up to the age of two years, but rarely causes cellulitis in adults. The article covers treatment options such as mupirocin ointment, which is highly bactericidal to all common primary skin pathogens, and various broad-spectrum systemic antibiotics, which can be used for severe manifestations.

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