

## A journal club meeting: Liver disease and impotence

**To the editor:** Journal club meetings with small GP/family medicine groups take place across the country on a regular basis. What can happen at these meetings? There is no sponsorship. One person volunteers to do the leading. We use articles from the South African Family Practice Journal, The South African Medical Journal, Update, Continuing Medical Education etc.

This time we talked about liver disease. Some 'new facts' emerged and seemed worthy of sharing:

What was NASH or NAFLD? NASH stands for non-alcoholic steato-hepatitis i.e. fatty liver with inflammation and fibrosis. Its' antecedent, NAFLD: non-alcoholic fatty liver disease is a milder but more common form of liver disturbance. This condition has a prevalence of 24% in some populations and occurs in up to 74% of obese individuals and one third of patients with type 2 diabetes! NAFLD is common and can move on to NASH which can become cirrhosis or even hepato-cellular carcinoma. NAFLD is now believed to be a manifestation of the metabolic syndrome. (1) In a patient who has two out of the following five criteria one can diagnose the metabolic syndrome:

- Abdominal obesity: waist circumference > 102 cm for men and > 88 cm women
- Hypertriglyceridaemia: TG > 1.69 mmol/l
- Reduced HDL: men < 1.03 and women < 1.29 mmol/l
- Hypertension : >150/85 mmHg
- Fasting blood glucose > 6.1 mmol/l

This was all a bit shocking. We looked around the small room and wondered if the metabolic syndrome was amongst us. Were these facts and figures based on hard science and was that science driven by capitalism which in turn is driven by sales of commodities be they tests, medication or a whole service industry! What would this mean in practice?

We went on to consider the metaphoric meaning of the liver. It was postulated that an ill liver represented a blocked system at some deeper level. A patient study was presented that grappled with the idea of repression or 'blockage'.

It went as follows: A man in his early twenties presented to the doctor with his mother. On entering the consulting room there was talk between mother and son about a fear.

It had something to do with words and symbols and language and understanding. The mother thought the son had said something about fear of the BIG CA, but in fact there was a concern about being 'gay', the 'g' being phonetically expressed as a 'k'. The doctor at this stage realized the mother was no longer needed.

He adroitly moved through the dance of addressing the 'individual' and the 'contextual' aspects of the story and uncovered the following. The young man was being invited into sexual relations by his girlfriend. Each event led him to confront an inexplicable impotence. The doctor enquired about any sort of 'blockage' being experienced by the man. He was worried that the impotence was related to being 'gay'. It turned out he bore a fear of siring an illegitimate child. His girlfriend was not on a contraceptive. His father had sired a child out of wedlock. His mother had expressed anger and despair at the situation in the past, and fear of it happening again.

Once the doctor helped make the connection between these seemingly disconnected events, and advised access to suitable contraception for his girlfriend, the man left confident and prepared. We applauded the doctors' management and diagnosis.

An hour of journal club time had elapsed. What does liver disease and impotence have in common? Nothing directly, except that animated discussion and learning can move along laterally. This is family medicine at its best: on the one hand there is this unstoppable barrage of fascinating and important facts and developments to integrate into our practice, on the other is the process of interpreting 'illness' wisely. So at one and the same time, we are committed biomedical scientists and psychosocial experts. To keep a balance is not easy, but it makes our branch of the medical profession a challenge worthy of a life-times work.

### **Rosochacki, Z**

Family physician and extraordinary lecturer in family medicine  
Stellenbosch University  
zandyros@samedical.co.za

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