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Screening for skin cancer in Queensland: who attends, and why and where do they attend?

Philippa H Youl, Peter D Coxeter, David C Whiteman and Joanne F Aitken

To the Editor: A number of commentaries and articles have been published recently about the ability of doctors working in primary care skin cancer clinics to diagnose and manage skin cancer.[1-3] However, limited information has been published comparing the patient populations that attend the different service providers (ie, "traditional" general practitioners versus doctors at skin cancer clinics).

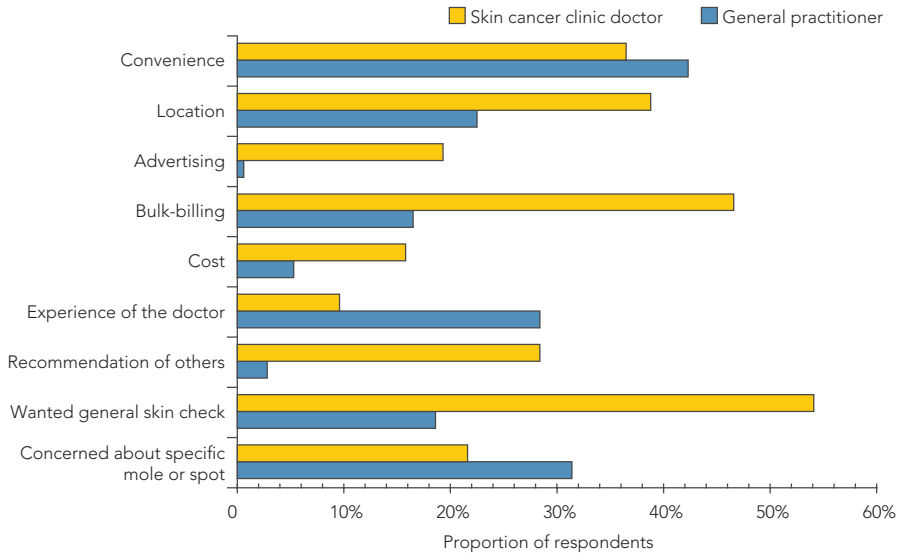
In 2005, we conducted a large population-based survey of Queensland residents aged 20–75 years to examine the prevalence of behavioural risk factors for cancer and current cancer screening practices.[4] Using data from our study, we examined the prevalence of clinical skin examination and identified factors associated with choice of service provider. A total of 9419 respondents completed the interviews (response rate, 45.6%). Complete data for this analysis were available for 5499 of the respondents, of whom 48.2% were men.

Thirty per cent of respondents reported they had had a general check of all or nearly all of their body in the previous 12 months. Factors associated with an increased likelihood of having a whole-body skin examination in the previous 12 months included being male (odds ratio [OR], 1.15 [95% CI, 1.00–1.31]), being 60–75 years of age (reference group, 20–39 years) (OR, 1.73 [95% CI, 1.45–2.07]) and having an annual gross income of ⩾ $60 000 (reference group, < $20 000 annual gross income) (OR, 1.42 [95% CI, 1.18–1.71]). The strongest predictors were a self-reported history of melanoma (OR, 2.68 [95% CI, 2.01–3.57]) or non-melanoma skin cancer (OR, 2.01 [95% CI, 1.65–2.45]).

No associations were seen between choice of service provider and any sociodemographic variables, including sex and age group. Additionally, skin cancer risk factors (such as having highly sensitive skin or a history of melanoma) did not make respondents any more or less likely to attend either a GP or a skin cancer clinic doctor. Various reasons were given by respondents for their choice of service provider (Box). Skin cancer clinics appeared to be chosen primarily because they offered bulk-billing or because respondents just wanted a general skin check. Traditional GPs were more likely to be chosen for convenience or because of concern about a specific spot or mole.

Skin cancer is a major public health issue, and the provision of adequate and appropriate clinical services is a continuing and growing challenge. We found that a significant proportion of the Queensland population had undergone a whole-body skin examination by a doctor within the previous 12 months, and that those attending appeared to be the group most at risk of developing skin cancer. We did not find any significant differences in the profiles of those who chose a skin cancer clinic or a general practice for their skin examination.

Reasons given for choice of service provider* by 2895 respondents who had had some type of skin check in the previous 12 months†



* General practitioner or skin cancer clinic doctor. † Percentages do not total 100 due to multiple responses.◆

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Community acquisition of ESBL-producing *Escherichia coli*: a growing concern

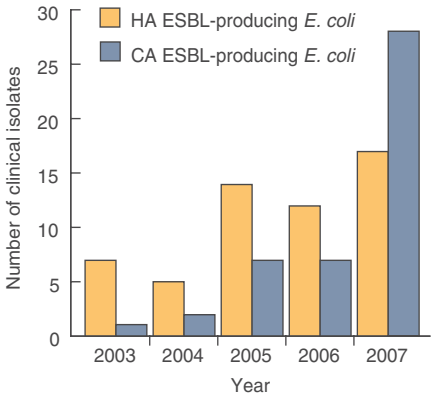
Justin T Denholm, Michael Huysmans and Denis Spelman

To the Editor: Extended-spectrum-β-lactamases (ESBLs) are enzymes capable of hydrolysing penicillins, broad-spectrum cephalosporins and monobactams. Worldwide, ESBL-producing organisms are posing an increasing challenge for empirical antibiotic use and infection control.

We recently carried out a review of microbiological isolates from clinical specimens taken from 2003 to 2007 at the Alfred Hospital, Melbourne. From 15 917 gram-negative bacilli, we identified 234 ESBL-producing organisms (1.5% of isolates) using double-disk synergy testing.

Over the 5-year period, we noted three apparent changes in ESBL epidemiology relating to *Escherichia coli* isolates. First, *E. coli* became the most frequent organism in which ESBL production was observed, making up 55.6% of all ESBL-producing organisms in

Hospital-acquired (HA) versus community-acquired (CA) ESBL-producing *E. coli* isolates, Alfred Hospital, 2003–2007



E. coli = *Escherichia coli*. ESBL = extended-spectrum-β-lactamase. ◆

2007 (up from 23.5% in 2003) ($P = 0.03$). Second, while the total number of *E. coli* isolates remained essentially constant over the study period, there was an increase in the proportion of *E. coli* isolates found to produce ESBLs: 1.8% of *E. coli* isolates in 2007 compared with 0.36% in 2003 ($P < 0.001$). The third and perhaps most striking change was in the epidemiology of ESBL-producing *E. coli*. In 2003, ESBL-producing *E. coli* infections were largely hospital-acquired, with 87.5% of isolates acquired after 48 hours in hospital or after a hospital admission in the previous 12 months. However, by 2007, ESBL-producing *E. coli* infections were found to be predominantly community-acquired, making up 62.2% of ESBL-producing *E. coli* isolates ($P = 0.01$). The increased proportion of community-acquired infections occurred despite a parallel increase in the frequency of hospital-acquired ESBL-producing *E. coli* infections (Box).

Community-onset infections with ESBL-producing organisms have become increasingly recognised as important clinical entities.[1] ESBL-producing *E. coli* bacteraemia is associated with higher mortality than bacteraemia caused by non-ESBL-producing organisms,[2] a finding that has also been specifically demonstrated in the setting of community-acquired infections.[3] Although local epidemiological data for infections with ESBL-producing organisms are not readily available, it appears that rates of community-associated infection vary greatly worldwide, with some regions of China reporting rates of ESBL-producing *E. coli* as high as 34% of all isolates.[4]

Although our study was limited by being a single-centre review, our findings are consistent with the emergence of multiresistant *Enterobacteriaceae* noted in Australian surveillance reports.[5] It is not clear whether the change in our ESBL-producing isolates is reflective of local resistance patterns, or perhaps associated with travel to regions where ESBL-producing *E. coli* are known to be prevalent. Corroboration of these changes in other regions will be important for assessing the magnitude of this issue and responding appropriately, particularly in considering empirical antibiotic therapy for community-acquired gram-negative infections.

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Prevalence of self-reported allergies to food in Australia as assessed by Internet-based questionnaires

Katrina J Allen, Jennifer J Koplin, Carmen Gould and Nicholas J Osborne

To the Editor: Reported adverse reactions to food, which are common in many developed countries, can be produced by a wide variety of mechanisms. However, a low proportion of these are true food allergies.[1] Recent Australian data show an increase in hospital presentations for food-induced anaphylaxis,[2,3] but there are no Australian population data on the prevalence of either food allergies or adverse reactions to foods. Waiting lists for allergy services continue to remain long, and it is not known whether this is due to an increase in the prevalence of true food allergy or simply an increase in perceived food allergy.

In October 2007, we undertook an Internet-based survey to assess the prevalence of self-reported perceived food allergies in Australian households. Participants were drawn from a consumer research panel of 8385 people (solicited through Internet-based marketing) who were proportionally representative of the Australian population with respect to age, sex and state. Cohort members were invited to participate in an Internet-based "health survey", with no mention of food allergy during recruitment. Within 24 hours we had 1386 respondents and the required quota of participants was deemed to have been reached.

Of the 1386 respondents, 406 (29.3%) reported at least one household member who believed he or she had a food allergy (Box). Of these, 250 (61.6%) reported at least one doctor-diagnosed allergy and 56 (13.8%) reported that the allergy was allergist-diagnosed. In addition, 42 respondents (3.0% of all respondents) reported that the person with the allergy had an EpiPen (Dey, LP, Napa, Calif, USA).

Although there will be some selection bias in our sample because people without Internet access could not be sampled, we believe this bias is likely to be low, as at least 64% of the Australian population currently has home access to the Internet.[4]

Proportion of Australian households in which at least one member believed they had a food allergy, and the individual foods nominated*

Food	Incidence of allergy (%)	
	All households surveyed	Households with perceived food allergy
Cows milk	8.3	28.3
Peanut	6.9	23.4
Shellfish	5.9	20.2
Wheat	5.6	19.2
Fruit	5.3	20.9
Egg	3.4	11.6
Vegetables	2.7	6.7
Fish	2.5	8.4
Tree nuts	2.2	7.4
Soy	1.7	5.7
Other	6.3	21.4

* 40% had more than one food allergy. ◆

Our questionnaire did not attempt to distinguish between true food allergy, sensitisation to foods, food intolerance or adverse reactions to food, although the majority of allergies had been diagnosed by a doctor or allergist, and foods such as peanut are more likely to be associated with allergies than intolerances. The high rate of perceived allergy to fruit and vegetables in an Australian context was surprising, although allergic reactions to fruit and vegetables are well documented.[5] This may reflect either a rising prevalence of birch-pollen syndrome, as has been reported in Europe,[6] or a community poorly informed about the true nature of food allergy reactions.

Our data add to the evidence that there may be an increasing, largely unmet demand for health care information for patients with adverse reactions to food, including allergies. More formal evaluation should be undertaken to assess the type and prevalence of food allergy in the Australian context in order to facilitate future workforce planning and better community education.

Competing interests: Carmen Gould is employed by Mobileworld Operating Pty Ltd, which is majority owned by the Ilhan family, founders of the Ilhan Food Allergy Foundation.

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Prevalence and correlates of three types of pelvic pain in a nationally representative sample of Australian women

Jules S Black

To the Editor: So a large proportion of women experience pelvic pain, often over years. What's new? Of course they do. Pitts and colleagues[1] fail to mention that virtually every normal, physiological event that occurs within a woman's pelvis is associated with pain. Clearly, such pains vary in duration and intensity and are associated with events such as ovulation, menstruation, pregnancy, labour and childbirth. We men have it easy by comparison. But to conclude by saying that "only about a third of women who experience chronic pelvic pain seek advice from a health professional" gives the impression the authors are trying to medicalise yet another essentially normal event.

One can get into long, philosophical discussions as to why such normal events should be so painful, but it remains a fact. I have spent my career urging general practitioners and fellow specialists to avoid surgery and "silver bullets" in most cases of pelvic pain and follow a conservative approach.[2] It would have been more helpful if the authors had gone on to discuss what type of pain is suffered by what type of woman and who is treated by what type of doctor. This truly would have assisted in determining who would benefit from the attention of a health professional and who would not.

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David Vivian and Adele Barnard

To the Editor: We read the recent article by Pitts and colleagues[1] with interest, given the rising trend of diagnosed chronic pelvic pain (CPP) in Australian women. The article identified three types of CPP, but did not differentiate pain into the two major categories of nociceptive (visceral and somatic) and neuropathic. In pain management settings it is considered essential, where possible, to make this differentiation, as it significantly alters management strategies, particularly in relation to medication. While the true incidence of neuropathic pain is unknown, it is believed to be underdiagnosed and inadequately treated. A 2008 French study based on a nationwide postal survey revealed a 6.9% prevalence of neuropathic pain in the general population, with 5.1% of respondents reporting pain levels as moderate to severe.[2]

Neuropathic pain results from damage to the nervous system. Specifically, this can be from damage to, or pathological changes in, the axons of peripheral nerves or from damage to the central nervous system, probably as a result of deafferentation. This is the process whereby neurones in the central nervous system lose their accustomed afferent input, either from a peripheral nerve or from an ascending sensory tract. Furthermore, neuropathic pain can and does cross neuroanatomical boundaries, often presenting viscerally as referred pain and eliciting pain descriptors such as burning, shooting, stabbing, and searing. For this reason, CPP is often wrongly assumed to be visceral in origin.[3] In such cases, awareness that CPP may in fact be neuropathic may avoid inappropriate surgical interventions. Moreover, an association between CPP and neuropathy has been demonstrated in studies of sacral nerve and percutaneous tibial nerve stimulation in women presenting with CPP.[4,5]

Differential diagnosis of pain of neuropathic origin has been shown to be pertinent for the accurate implementation of pain management strategies.[6] Therefore, we suggest that future studies on the epidemiology and/or prevalence of pain include tools to determine the proportion of pain of neuropathic, nociceptive and mixed origin. There are a number of tools available, including questionnaires such as painDETECT, DN4 (Douleur Neuropathique en 4), LANSS (Leeds Assessment of Neuropathic Symptoms and Signs) and NPS (Neuropathic Pain Scale). Some of these, such as the self-assessed LANSS (S-LANSS), do not require clinical examination and thus can be worked into population-based questionnaires. The ability to identify neuropathic pain should lead to individualised treatment, resulting in improved pain control for patients with CPP.

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Marian K Pitts, Jason A Ferris, Anthony M Smith, Julia M Shelley and Juliet Richters

In reply: We are pleased to see our article about chronic pelvic pain in Australian women has provoked interest.[1] Black's suggestion that virtually every normal physiological event that occurs within a woman's pelvis is associated with pain is surprising, and not supported by our evidence. Of the women in our sample, 23% were totally pain free, and most of the chronic pelvic pain reported was mild. A parallel study showed that men also suffered chronic pelvic pain — a smaller proportion than women, but still significant.[2] We are not medicalising normal events; rather, we are alerting general practitioners to the normal range of pelvic pain experience to help them assess its clinical significance. A GP who says to a female patient "it's normal, love, just grin and bear it" denies the psychosocial complexity of her experience.

Vivian and Barnard suggest we might have differentiated between two major types of pain, nociceptive and neuropathic. It would not be practical to collect this information in a broad survey on sexual and reproductive health. Certainly, a study of the prevalence of neuropathic pain in the Australian population that mirrors recent studies overseas would be informative. However, our study concerned pelvic pain only. The pelvis is not a common site for neuropathic pain.[3]

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