Guest editorial

Specialist referral – when is it appropriate?

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After obtaining the FCP (SA), Vanessa Burch trained as a rheumatologist and was appointed as a senior specialist in the Department of Medicine at the University of Cape Town. In 2002 she was appointed head of the Department of Medicine at GF Jooste Hospital, a community-based teaching hospital affiliated with UCT. One of her main interests is the efficient delivery of equitable, affordable health care in South Africa.

With the advent of improved access to health care, particularly at primary care level, a greater number of South Africans are in need of specialist care. As a consequence, the workload at specialist level continues to increase. For example, the number of outpatient visits at a tertiary centre such as Groote Schuur Hospital has increased from 466 885 to 481 808 over the past 3 years. This increased demand for specialist care comes at a time when inpatient tertiary services are being limited in order to strengthen primary level services. As a result, tertiary level services are experiencing an increasing workload in the face of diminishing resources. The most appropriate response to this difficult situation is to develop national guidelines for specialist referral and treatment of medical conditions commonly encountered in primary care practice in South Africa. This edition of *CME* represents a first attempt at developing such referral guidelines. The authors who have contributed to this edition represent several academic centres in South Africa, hence providing national input rather than centre-specific opinions. This edition, therefore, paves the way for further collaboration in the development of referral guidelines that should be a priority issue so as to provide equitable, affordable health care for all South Africans.

The paper by Professor Mzileni provides a comprehensive pictorial overview of common chest radiograph abnormalities frequently encountered in routine clinical practice. Her article provides a practical approach to the evaluation of consolidation, lobar collapse, unilateral increased lung translucency, pulmonary mass lesions, diffuse pulmonary opacification of a linear, nodular or reticular nature, radiological features of airway disease, mediastinal abnormalities and pleural abnormalities. The radiographs in the article are a useful reference source for busy clinicians who do not have time to review exhaustive texts to identify the radiographic abnormalities discussed in this paper.

Given the high prevalence of TB in South Africa it is not surprising that I have included a paper dealing with the management of TB not improving on standard therapy. The paper by Professor Willcox succinctly outlines eight reasons why patients with TB may fail to improve – wrong diagnosis, co-existent condition, poor compliance with therapy, drug resistance, vomiting, malabsorption, inadequate drug levels and poor-quality medication. He stresses the importance of having a high index of suspicion for drug resistance or inadequate drug levels in patients in whom common causes of therapeutic failure have been excluded. Currently the prevalence of INH resistance in South Africa is about 10%. Multidrug resistance (MDR), defined as resistance to INH and rifampicin with or without other drugs, has a combined prevalence of between 2.5% and 4.5%. Given the high prevalence of TB in South Africa, these statistics translate into thousands of patients with drug-resistant TB. The recent discovery of extremely drug-resistant TB further compounds the problem and highlights the need for vigilance when treating patients with TB. The paper provides clear guidelines regarding the use of a standardised MDR treatment plan, and also mentions the need for rapid diagnostic tests that can easily identify drug-resistant TB strains within 72 hours of sputum collection. The need for these tests in the public sector health care service is apparent. In addition he refers to the availability of serum drug levels for rifampicin in selected centres in South Africa. The utility of this test and its role in the management of complicated TB cases is briefly outlined.

This edition of *CME* also contains a paper dealing with the management of common conditions affecting HIV-positive patients. The paper by Drs Meintjes, Wilson and Venter outlines the management of, and the need for specialist referral of, HIV-positive patients with advanced infection and suspected TB, neurological and psychiatric problems, liver disease, chronic diarrhoea, Kaposi's sarcoma and new-onset visual problems. The second part of the article outlines problems encountered in patients taking antiretroviral medication. These problems include immune reconstitution syndrome and antiretroviral drug toxicity – hepatitis, hyperlactataemia and acidosis, skin rashes, myelosuppression, pancreatitis, peripheral neuropathy and metabolic syndrome. The paper provides a number of very useful tables and investigation/treatment algorithms which are ideally suited to primary care practice.

Diabetes mellitus and hypertension are two of the leading non-infectious causes of morbidity and mortality in South Africa. The paper by Professor Mollentze provides a good overview of the long-term management of diabetic patients and clearly outlines those conditions requiring specialist referral – acute metabolic emergencies, life-threatening infections, diabetes during pregnancy, eye care, renal care, troublesome neuropathies, foot care and cardiovascular risk management. He emphasises the important role played by a host of health care professionals who provide essential care in the management of diabetic patients, including pharmacists, dieticians, diabetic nurse educators, psychologists, dentists and podiatrists.

The topic of hypertension requiring specialist referral is addressed in a paper by Professor Rayner. He highlights the problems of resistant hypertension, hypertensive urgency and emergency, suspected secondary hypertension, hypertension associated with significant co-morbidity, masked or nocturnal hypertension and patients intolerant of multiple antihypertensive drugs. This succinct contribution provides clear guidelines regarding the referral of the conditions listed.

Professors Commerford and Doubell provide a superb table outlining commonly encountered cardiac conditions and an outline of the most appropriate care at the primary, secondary and tertiary level. The table deals with ischaemic heart disease, valvular heart disease, heart failure of uncertain cause, symptomatic heart block, syncope of unknown cause, aortic dissection, asymptomatic murmur, pericardial effusion, constrictive pericarditis, atrial fibrillation/

flutter, narrow complex tachycardia and ventricular tachycardia. The table is concise and clear and should serve as an easy-to-use reference document in busy clinical settings.

The final paper in this edition of *CME* provides a broad overview of falls, dizziness and syncope in the elderly. This ties in well with the recent *CME* edition addressing common problems in the elderly. In the current paper Drs De Villiers and Tipping provide a number of easy-to-understand figures and algorithms in which they depict the common causes of falls, dizziness and syncope. The information is easily accessible to the busy clinician and provides clear guidelines for the referral of postural hypotension, dizziness on exertion, vertebrobasilar insufficiency, carotid sinus hypersensitivity, 'drop' attacks and suspected cardiac syncope.

The purpose of this issue of *CME* is to provide busy primary care clinicians with user-friendly easy-to-read guidelines that clearly outline the need for specialist referral when managing conditions commonly encountered in routine clinical practice in South Africa.