



Kidney disease rate rising 3 times faster in BC

The kidney dialysis population is rising rapidly in British Columbia, prompting the BC branch of the Kidney Foundation to distribute a new guide to 3000 family doctors alerting them about early warning signs of kidney failure. The foundation says that the incidence of kidney disease is increasing by up to 15% a year in the province, compared with 5% nationally.

Currently, 445 people are waiting for kidney transplants in BC and the waiting time — 4 years — nearly doubled in 1999. The demand for dialysis has leapt from 900 people in 1996 to 1500 in 1998.

“We don’t know all the reasons why the dialysis population is growing,” says Dr. Adeera Levin, director of the British Columbia Renal Agency. “It may be that the rate of kidney disease has increased or it may be that the rate of referral to dialysis has increased.”

Other reasons for the increase can be found in BC’s unique population structure. The prevalence of diabetes, the leading cause of kidney failure, is rising rapidly among the aboriginal and Asian populations. As well, the number of senior citizens is growing rapidly as more and more people retire to the warmer West Coast. More seniors are also surviving heart disease and diabetes, and some are left with kidney disease. The average age of new patients with kid-

ney disease — now 60 — has been increasing steadily in recent years. About 40% of new dialysis patients present “out of the blue” from within this older age cohort, Levin says.

Levin hopes that the new brochure will make family doctors more aware of the importance of early diagnosis. “There’s no question that early identification can delay progression of renal disease, improve patient outcomes, even potentially lead to the avoidance of dialysis by getting pre-emptive transplants. And you need time to organize all that.”

About 20% of patients, if diagnosed early enough, can delay or avoid dialysis altogether. “There is a huge role for the general practitioner to play. If you know someone has early renal disease, you don’t give them certain medicines because you know those are harmful to the kidneys. It’s not just about referring but about knowing how best to treat the patient.”

Can BC’s 28 nephrologists handle the estimated 1700 patients who will need dialysis by the year 2000? Levin says that more specialists are needed across the country, but co-management of patients by family doctors can help overcome the shortage. Of more concern, she says, is the lack of nurses and technicians in renal dialysis units. “We could build a unit tomorrow with machines in it, but there would be no one to staff it.” — © Heather Kent, Vancouver



New expanded guidelines for preventing HIV

For the first time, HIV prevention guidelines from the Canadian AIDS Society and Health Canada include risk factors other than sexual transmission of the virus. The 46-page *HIV Transmission: Guidelines for Assessing Risk* includes information on safer injection techniques for drug users and advice for pregnant women and people having their bodies pierced or tattooed.

Based on a comprehensive review of research over the last 5 years, the guidelines offer a scientific framework for judging the levels of risk of HIV transmission for various activities. In order to reach a wider audience the language used is blunt, and includes many words that are not used in polite company. Unlike previous versions, this third edition focuses on providing information and support to help people make informed decisions. The guidelines have been translated into 12 languages and are internationally renowned as the authoritative document on HIV transmission. For more information, visit www.cdn aids.ca.



First female FP dean shatters another glass ceiling

Dr. Carol Herbert believes that the “flexibility and breadth of a generalist” is an advantage in her position as the first female family practitioner to be appointed dean of medicine in Canada.

“I thrive on uncertainty and a dean lives in an uncertain world and needs to be flexible,” says Herbert, who will soon be moving from UBC to her new job as dean of the combined faculty of

medicine and dentistry at the University of Western Ontario in London.

Herbert’s appointment is the third in a year of firsts for women and FPs, a year of “breaking glass ceilings,” as she puts it. The first female physician to become a dean of medicine in Canada was Dr. Noni MacDonald, a specialist in infectious diseases (see *CMAJ* 1999;160:1042), while Dr. Brian Hennen was the first Canadian family physician to be named a dean of medicine (see *CMAJ* 1999;160:1865).

Herbert is accustomed to firsts. She is a pioneer in providing services for sexually abused children, she helped found the Sexual Assault Service of Vancouver and she is a leader nationally and internationally in developing primary care research.

Herbert, 53, balances editing, research, writing, clinical practice, teaching and administration. She’s editor of an international journal and a member of *CMAJ*’s Editorial Board, and has published 60 papers; she has also coauthored 5 books. She has expertise in participatory research and her research interests include clinical health promotion, communication and influencing family physician behaviour and deci-

sion-making. She’s taught at UBC for 27 years and was head of its Department of Family Practice from 1988 to 1998. Meanwhile, she’s managed to keep her clinical practice going at least a couple of afternoons a week, and raised 6 children. “I like keeping all those balls in the air,” she says with a laugh. “It’s a personality quirk.”



Dr. Herbert: thrives on uncertainty

Agenda for CMA’s annual and business meeting set

The CMA’s annual business session, which is designed to allow members to ask questions of the Board of Directors, will be held in Ottawa Aug. 25, 1999, at the conclusion of the CMA’s 132nd annual meeting. Items on the agenda are the president’s report to the General Council meeting, the report of the board chair, the honorary treasurer’s report, approval of any bylaws passed by General Council and new business.

Cool sites

www.cc.gatech.edu/gvu/virtual/Phobia/

Just the thought of stepping onto a plane or an elevator sends some people into fits of apoplectic fear. These phobias can be debilitating and present a serious problem in our modern society. In exposure therapy, the standard treatment, the patient is gradually exposed to an increasing level of contact with the fear-inducing environment. Although effective, this treatment is costly and time consuming. Now, thanks to the Graphics, Visualization and Usability Center at the College of Computing, Georgia Tech University, there is an alternative. Using virtual-reality systems, researchers place patients in a world that looks and feels real but is completely computer generated. The first controlled study of virtual-reality exposure therapy was shown to be effective in treating acrophobic subjects, and current work involves phobias surrounding flying. This virtual treatment is much cheaper, since exposures can take place in the office, and it is also easier to control, avoiding unexpected and debilitating surprises. — *Dr. Robert Paterson*, rbpatterson@attcanada.net

Million dollar MD loses Ontario licence

The Ontario GP who lost \$1 million in billings after an investigation by Ontario’s Medical Review Committee has now lost his licence to practise in that province.

Due to confidentiality provisions in the Health Insurance Act (1994), the 45-year-old physician can’t be identified. However, the case did raise the ire of many Ontario physicians. The urban GP was reportedly seeing between 150 and 300 patients per day (see *CMAJ* 1999;160:1617). He is also alleged to have billed for services he didn’t provide, to have kept scanty patient records and to have seen patients when it wasn’t medically necessary.



Pulse

The changing face of AIDS in Canada

New Health Canada data indicate that the number of patients diagnosed with AIDS in Canada had reached 16 236 by the end of December 1998. The total included 14 917 male adults, 1130 female adults and 187 children; the sex and/or age of 2 patients was unknown.

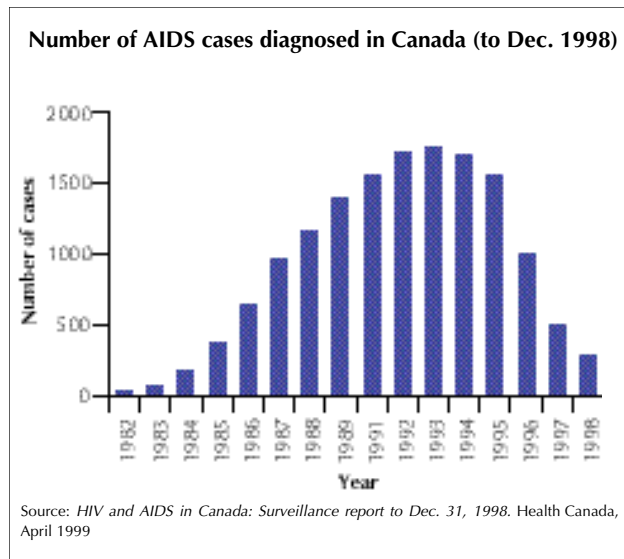
Females diagnosed with AIDS tended to be younger than males. More than one quarter (26%) of females were between 20 and 29 years old, compared with only 15% of

men. In 72% of cases involving males, the men were between 30 and 49 years old; only 52% of females were in this age group.

Adult women accounted for 12.4% of positive HIV tests reported between 1985 and 1998. This number has increased over the years, and in 1998 it represented 21.6% of all positive adult HIV tests in cases in which the person's sex was known.

The proportion of positive HIV reports attributable to heterosexual sex has increased steadily, accounting for 16% of cases in 1998 compared with only 6.2% between 1985 and 1994. Drug users account for an increasingly larger portion of the total number of positive tests, but the number may have peaked at 33.5% in 1997; by 1998 the figure had fallen to 29%. Male homosexuals, who once accounted for 75% of all positive HIV tests (1985-1994), now are responsible for just 36.5% of all positive tests in Canada.

For physicians, the best news is that the number of AIDS cases diagnosed in Canada declined to 279 in 1998, the lowest number since 1984. In the record year, 1993, 1751 cases were diagnosed. (By comparison, it is now estimated that 240 Zimbabweans die every day of AIDS-related causes.)



This column was written by Lynda Buske, Chief, Physician Resources Information Planning, CMA. Readers may send potential research topics to Patrick Sullivan (sullip@cma.ca; 613 731-8610 or 800 663-7336, x2126; fax 613 565-2382).

Military hopes pay hike will keep MDs in uniform

Physicians who agree to remain in the armed forces after completing their initial 4-year stint can look forward to much larger paycheques starting this year. In an attempt to curb the defections to private practice that are leaving the military desperately short of medical officers, the federal government has approved a pay increase that will see captains who stay beyond their initial 4-year commitment earning \$110 000 a year. They currently earn up to \$86 000 a year. The armed forces says a benefits package adds another 23% to the value of the pay package. Lieutenant-Colonel Henry Fla-

man, the physician responsible for recruiting doctors, says the new salary (plus benefits) is designed to match the net income of a family physician or GP who has been in practice for 5 years. Flaman said the new salary is based upon the Canadian average for a fee-for-service physician, using data provided by the Canadian Institute for Health Information.

Medical officers in their first 4 years of service will receive a 7.65% increase, bringing their salary to a

maximum of \$92 000 annually. The other pay increase, designed solely to retain medical officers beyond 4 years, is the second prong in a 2-pronged exercise. In a separate recruiting effort, the military recently announced an \$80 000 recruiting bonus to attract new doctors into the armed forces.

"We think the pay increase will have an impact," Flaman said. "Two or 3 doctors said they would stay once they heard about it."

Captains to earn \$110 000 annually



Research Update

Accurate test for nasopharyngeal cancer developed by Canadian researchers

Earlier diagnosis and treatment of a hard-to-detect type of cancer that is the leading cause of cancer deaths in Hong Kong, Southern China and many Mediterranean and Pacific Rim countries is a step closer to reality, thanks to a new test developed by Canadian researchers.

Dr. Michael Dosch, professor of immunology at the University of Toronto, has found that a modified version of the cytology brush is very accurate in diagnosing nasopharyngeal cancer. Cells are gently removed from the back of the nose, then subjected to DNA screening to confirm the presence of cancer.

In a study involving 178 patients with early- or late-stage tumours, Dosch and colleagues showed that the new procedure's sensitivity is more than 90% and specificity is around 98%. The findings,

published in the *Journal of the National Cancer Institute* (1999;91[9]:796-800), are being heralded as a significant first step toward screening in high-risk populations — which in Canada includes people of Chinese, Jewish and Inuit descent.

Dosch feels the new technique has the potential to reduce mortality rates significantly. "Early detection is almost certain to improve the poor prognosis of nasopharyngeal cancer. To date, over two-thirds of patients are not diagnosed until the disease reaches a late or very late stage."

Worldwide, about a million new cases of nasopharyngeal cancer are detected annually. Because of their location deep in the nose, the tumours often grow undetected. As a result, prognosis is poor: 10-year survival rates run as low as 10% to 20%. Although

the risk drops quickly when Chinese people immigrate to Canada, it is still 40 to 50 times higher than in Canadians of European descent.

Epstein-Barr virus (EBV), carried by almost all adults, is believed to be a central player in the development of nasopharyngeal tumours — EBV is present in all cells from them.

"With the ability to detect early [tumours] routinely, we [already are] considering new approaches to therapy that focus on the unique characteristics of this cancer, which is really an infectious disease quite distinct from other, non-EBV cancers," says Dosch.

Dosch and colleagues are currently planning a large, population-based clinical trial, "to help translate what we've done into practical medicine." — © Greg Basky, Saskatoon

CMA ready to launch one-of-a-kind source of CPG info

The CMA is gearing up to launch its improved *CPG Infobase* (www.cma.ca/cpgs), the country's largest database of Canadian clinical practice guidelines (CPGs). Recent data indicate that the *CPG Infobase*, created in 1996, is the second most popular public resource on *CMA Online*, trailing only *CMAJ*.

CPGs are designed to help physicians and patients make complex health care decisions. Using a menu-driven interface, the *CPG Infobase* provides free access to the full texts or structured abstracts of more than 650 current Canadian CPGs. When available, related publications, such as patient material and quick reference guides, are also provided. These CPGs represent a subset of more than 2000 CPGs listed in a rich internal database.

The new *CPG Infobase* will offer direct searching of the internal database via a newly developed search engine. A CMA project team began working last summer to create a workable interface. Potential users were also involved throughout the process. In January, 11 partici-

pants, including 5 physicians, "test drove" the prototype and provided valuable feedback. This same group, plus several new volunteers, will participate in beta testing of the "live" database before it is formally launched this fall.

The new search engine will include both quick and advanced user interfaces, with searching by keyword or phrase as well as coded fields, such as Medical



Subject Headings or gender. An expert, command-driven interface is also under consideration. Users will be able to display, print or save search results in a variety of formats, and to save their search strategy for future use. Useful resources

from the original *Infobase* will continue to be available, including a list of recent full-text additions and links to guidelines on featured health topics.

With the introduction of the new interface, the *CPG Infobase* will become the only comprehensive source for information on and access to current Canadian CPGs. It will be demonstrated at several physician conferences this year. — Becky Skidmore, CPG Database Manager, CMA