Letters

I READ THE 'Management of chronic pain in a rural Australian setting: Findings from the Crossroads-II mixed-methods study' published in the *AJGP* January–February 2024 issue with interest.[1] Twenty per cent of community reported chronic non-cancer pain (CNCP) is often associated with significant health comorbidities. One-third of respondents report their pain is not well managed despite reporting satisfaction with their care.

The study identifies 'the need for further support to rural residents ... and the general practitioners (GPs) and other health professionals who care for them'.[1] As an experienced rural GP for many years who has reinvented himself as a GP specialist in pain management in the Wimmera for the last six years, I wholeheartedly agree. GPs need help.

The GP-referred patients I see have rarely been examined, nearly always had scans, often been given a clinically incorrect explanation based upon that result, tried conservative treatment and usually been prescribed opioids, which most would prefer not to take. Could we not do better?

GPs' diagnostic skill lies in pattern recognition. Based on our recognition, we know what to do next. The vast majority of CNCP presentations are one of three patterns:

- Generalised pattern: due to pain system sensitisation, presenting as widespread pain and often accompanied by sensory and highly emotional components.
- Localised radicular: pain that spreads from central to peripheral areas.
- Localised non-radicular: pain located in a specific area without referral.

Although any individual person might have one, two or all of these patterns, the importance of this understanding is that each pattern has a different pathway leading to researched passive therapies that can be directed by GPs. I believe this has the potential for transforming GP management of CNCP and turning the heartsink feeling into curiosity, for the benefit of all. I have started sharing this approach in the Wimmera and to rural GPs via The Royal Australian College of General Practitioners (RACGP) webinars.

People want to feel heard, respected and hopeful. It is my experience that thoughtful use of passive therapies reduces the pain burden a person is feeling, restores hope and increases the motivation to maintain the gains through active self-management. GPs confident with CNCP could also reduce the need for more specialist services.

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Competing interests: None.

Reference

1. Glenister K, Gray S, Bourke L, Simmons D. Management of chronic pain in a rural Australian setting: Findings from the Crossroads-II mixed-methods study. Aust J Gen Pract 2024;53(1-2):62–69. doi: 10.31128/AJGP-01-23-6695.

Reply

We read with interest and appreciation the Letter to the Editor by a general practitioner (GP) specialist from the Wimmera, in response to our recent paper.[1]

The author discusses the benefits of sharing their experience and expertise in pain management with rural colleagues and via patient referrals or webinars. Primary care multidisciplinary pain management is recommended in guidelines, and GPs report that the approach is useful.[2] Medicare-funded case conferencing can be used in a similar way to that used for diabetes,[3,4] to connect GPs and patients with pain specialists, nurses and allied health professionals. Case conferencing would provide GPs with specialist and multidisciplinary knowledge while reducing travel burden and waiting times for patients. Indeed, the respondents with chronic pain in our study typically travelled a short distance to their GP (83.5% travelled <5 km); however, they travelled much further to their primary specialist (20.3% travelled 50–100 km and 36.6% travelled >100 km). Respondents with chronic pain reported that they had visited a GP an average of 11 times in the previous 12 months, suggesting frequent opportunities to explore whether case conferencing would be of benefit.

We agree that patients want to be heard, respected and hopeful. A proportion of the respondents with chronic pain in our study (n=167) answered additional questions from the United Kingdom's GP patient survey.[5] A majority responded that the GP they saw most recently was good or very good at listening to them (88.1%), involving them in decisions about their care and treatment (84.9%), treating them with care and concern (89.7%) and taking their problem seriously (85.5%). When asked whether they had trust and confidence in the healthcare professional that they saw during their last GP appointment, most respondents responded 'yes, definitely' (74.7%) or 'yes, to some extent' (21.7%). These findings point to GPs being in an excellent position to support patients with chronic pain.

We again thank the GP Specialist for their work supporting rural and other Royal Australian College of General Practitioners (RACGP) colleagues, and encouraging us all to strive to provide rural patients with optimal person-centred care to manage chronic pain.

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Competing interests: None.

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1. Glenister K, Gray S, Bourke L, Simmons D. Management of chronic pain in a rural Australian setting: Findings from the Crossroads-II mixed-methods study. Aust J Gen Pract 2024;53(1-2):62–69. doi: 10.31128/AJGP-01-23-6695.
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THE USEFUL RECENT ARTICLE by Kelly et al[1] published in the *AJGP* January–February 2024 issue about non-healing leg ulcers surprisingly fails to mention scurvy as a possible cause.[2] Scurvy could easily have been included under the heading 'Nutritional screening' in Table 3 without increasing the word count of the article.

Because blood specimens for testing of vitamin C levels must immediately be put on ice in light-proof wrapping and centrifuged and frozen within two hours of collection, for most patients in whom scurvy is suspected as a possible cause of their non-healing leg ulcers, it is more practical to advise them to start taking a vitamin C supplement (as well as improving their diet, of course).

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Competing interests: None.

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1. Kelly G, Bingley J, Muir J. The non-healing leg ulcer: A logical approach. Aust J Gen Pract 2024;53(1–2):49–52. doi: 10.31128/AJGP-03-23-6770.
2. Gunton JE, Bechara N. Vitamin C insufficiency in Australia: Underrated and overlooked? Med J Aust 2023;219(10):463–64. doi: 10.5694/mja2.52146.

Reply

Dr Frank makes a very important point about vitamin C deficiency as one of the many aetiologies for skin failure, and we thank him for his thoughts.

Our article aims to highlight the important, common aspects of secondary chronic non-healing wounds of the lower limb that are, in our experience, often overlooked by focusing on individual aetiologies such as nutritional deficiency.

These common aspects are:

- inadequate management of gravity-related oedema with anti-gravity measures (especially compression and elevation)
- inadequate containment of wound exudate, with subsequent failure to maintain optimum peri-wound skin health (the source of new epithelium)
- inadequate biofilm management (especially through deliberate, frequent wound debridement, akin to oral biofilm management through daily toothbrushing), with subsequent stalling of wound healing in the inflammatory phase rather than progression to the proliferative phase of healing.

Almost irrespective of treating an underlying aetiology such as vitamin C deficiency, a chronic skin wound will be maintained if these aspects of secondary healing are not reliably attended.

These common aspects need to be approached deliberatively, collaboratively and consistently.

They require caring engagement of patients who are often disaffected with medical care. Chronic wound care is neither quick nor easy, but it is most rewarding.

Dr Frank's letter and thoughts has allowed us an excellent opportunity to highlight the important message we aimed to share, and we are grateful to him for this opportunity.

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