Letters

Representation of hidradenitis suppurativa in the RACGP curriculum: A missed educational opportunity

To the Editor,

Hidradenitis suppurativa (HS) is a chronic, recurrent, inflammatory skin condition that profoundly affects quality of life. Early recognition and intervention in primary care are essential to reduce pain, scarring and psychosocial burden. However, diagnostic delay remains common, with patients often experiencing years of misdiagnosis before referral to dermatology.[1]

A review of the *2022 RACGP curriculum and syllabus for Australian general practice – Dermatological presentations* unit reveals that HS is mentioned only once, under the subsection 'disorders of sweating', alongside conditions such as hyperhidrosis and intertrigo.[2] No specific learning outcomes, competencies or clinical scenarios address HS diagnosis, staging or management. In contrast, detailed objectives are provided for conditions such as eczema, psoriasis and skin cancer.

This limited representation may inadvertently reinforce the under-recognition of HS in general practice, despite its prevalence (estimated at 1–4% of the population)[3] and significant comorbidity burden. Given the general practitioner's (GP's) pivotal role in early diagnosis and multidisciplinary care, greater curricular emphasis is warranted. Integrating HS-specific learning outcomes, covering diagnostic features, first-line medical management and psychosocial support, would align with The Royal Australian College of General Practitioners' (RACGP's) commitment to comprehensive chronic disease management.

I suggest that future updates to the RACGP curriculum include HS as a distinct chronic dermatological condition, with corresponding assessment examples and *gplearning* activities. Such inclusion could improve GP confidence and patient outcomes in this often-overlooked condition.

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Competing interests: None.

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References are available online only.

Response

Thank you for your interest in the *2022 RACGP curriculum and syllabus for Australian general practice*.

The curriculum articulates the core competencies and learning outcomes expected of general practice training in Australia. These outcomes encompass the knowledge, skills, values and behaviours required to practise independently as a specialist general practitioner (GP) anywhere in Australia.

The syllabus has been designed to operationalise these high-order outcomes. It provides a framework outlining the breadth and scope of content across general practice. It provides ideas for learning opportunities and references; however, it is not an exhaustive or prescriptive list. The syllabus will also not outline how to assess and manage conditions, as the best practice for each presentation or condition can change over time on the basis of new evidence or by context.

As the author noted, hidradenitis suppurativa is included in the guiding topics and content areas with disorders of sweating. The expectations articulated include identification and working with the patient to develop a management strategy. This could be seen to encompass the areas the author is concerned about being covered.

The number of times a condition is mentioned in the curriculum is not indicative of how serious the condition is or how prevalent it is.

It is acknowledged that hidradenitis suppurativa is not classified as a disorder of sweating by the International classification of diseases, 11th revision (ICD-11) and may be better placed within another grouping.

We thank the author for their feedback, which will be considered in the current review of the curriculum.

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Cardiovascular risk screening beyond the Australian Cardiovascular Risk calculator

Thank you for publishing 'Cardiovascular risk screening beyond the Australian Cardiovascular Risk calculator: A guide for general practitioners' in the March 2026 edition.[1] The article raises important points, but I would like to respectfully challenge several of its claims.

First, the assertion that a coronary artery calcium (CAC) score above the 75th percentile denotes high risk (>15% 10-year cardiovascular disease [CVD] risk) requires qualification. Consider a White woman aged 50 years with a coronary calcium score of 5, placing her on the 88th percentile per The Multi-Ethnic Study of Atherosclerosis (MESA) reference tool (https://tools.mesa-nhlbi.org/Calcium/input.aspx). If she is a non-smoker without diabetes, has no family history of CVD, a total cholesterol of 5.0 mmol/L, high-density lipoprotein of 1.5 mmol/L, and a systolic blood pressure of 125 mmHg with no relevant medications, the MESA Risk Score and Coronary Age Calculator (https://mesa-nhlbi.org/MESACHDRisk/MesaRiskScore/RiskScore.aspx) yields a 10-year risk of just 1.7%. This is clearly not high-risk, and conflating percentile ranking with absolute risk could lead to unnecessary patient anxiety and over-investigation.

Second, I take issue with the recommendation that typical ischaemic chest pain in the absence of CVD risk factors warrants an exercise stress test (EST) as the test of choice. A patient presenting with typical ischaemic chest pain symptoms in the form of crushing central chest pain, rated 9/10, accompanied by pallor, diaphoresis, and nausea, requires urgent emergency assessment – not an EST. In my view, traditional risk factors are a useful adjunct in asymptomatic patients but carry limited weight when a patient is actively symptomatic.

Third, the article's discussion of modifiable risk factors omits what is arguably the most significant: insulin resistance. The Dugani et al paper[2] examining modifiable risk factors for myocardial infarction in women identifies diabetes at the top of the list, followed by metabolic syndrome – both expressions of insulin resistance. Therapeutic carbohydrate reduction remains an evidence-informed and underutilised approach to addressing this risk.

Finally, the suggestion that general practitioners order CT coronary angiography (CTCA) for high-risk individuals overlooks a practical barrier: CTCA is not accessible under Medicare for GP-initiated requests, with out-of-pocket costs typically around $2000. In practice, these patients are far better served by direct referral to a cardiologist.

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The article by Smith et al[1] gives a concise summary of current approaches to cardiovascular disease (CVD) risk screening and offers an excellent screening pathway suitable for Australian general practitioners (GPs). However, as pointed out in the article, CVD screening is complex in the primary care setting, and overdiagnosis and overtreatment of patients is possible. Furthermore, the Australian Cardiovascular Disease (AusCVD) Risk calculator predicts the 5-year risk of ischaemic events and cardiac-death only and is silent on the risk of other types of cardiac disease such as heart failure (HF).

HF is a significant cause of morbidity and mortality at the individual level and nationally is responsible for many potentially preventable hospitalisations. Furthermore, the risk of HF in cancer survivors is higher than in the general population, because of oncological treatments that are potentially cardiotoxic, as well as shared risk factors with CVDs.[2] While assessing the risk from ischaemic events is entirely appropriate, the risk of other forms and causes of heart disease, such as HF following cancer, should also be considered.[3]

The CHERISH (cancer-specific HF prediction from electronic medical records (EMRs) in survivor healthcare) score was developed based on a large cancer survivorship cohort in the UK to assess the 3-year, 5-year and 10-year risk of HF in patients after cancer treatment.[4] It is calculated using administrative patient data available in primary healthcare EMRs and has been externally validated in multiple survivorship cohorts (nationally in Adelaide and internationally in Ontario, Canada and Oslo, Norway). The CHERISH score is an effective and simple tool for early identification of patients at risk of HF, and for assisting GPs to triage survivors who most urgently need diagnostic echocardiography and who might benefit from more intense cardioprotective therapy to slow the progression, or reverse, asymptomatic HF.

Ensuring the growing number of cancer survivors remain healthy after therapy, with incident HF prevented or managed, has benefits for patients, GPs, and the health system.[5] Assessing the risk of all common cardiac conditions using a non-invasive, administrative tool might be more efficient and patient-friendly for this vulnerable group of patients.

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The importance of minimising long-term antidepressant use

We recently argued that patients prescribed antidepressants should undergo regular review to consider whether continued prescribing or deprescribing is indicated.[1] The evidence supporting continued treatment is flawed since discontinuation trials showing that continuation of antidepressants prevents relapse are likely to be confounded by withdrawal symptoms. This applies to the Geddes meta-analysis, mentioned by Looi et al,[2] in which antidepressants were typically stopped abruptly or over only a few days. Such rapid discontinuation is well recognised to produce withdrawal symptoms that overlap with relapse measures, fundamentally undermining confidence in estimates of relapse prevention.[3]

Alongside doubtful evidence of benefit, there is clear evidence of harm with continuing antidepressants long term including emotional numbing, sexual dysfunction, weight gain, diabetes and, in older adults, increased risks of falls, fractures and possibly premature mortality.

Looi et al agree that antidepressants should be reviewed regularly and discontinued when harms outweigh benefits. However, they do not address our central argument regarding the methodological limitations of discontinuation trials concerning their confounding by withdrawal symptoms. Looi et al also provide no evidence supporting their assertion that antidepressants remain beneficial for long-term treatment of recurrent moderate-to-severe depression. Long-term antidepressant use may only be beneficial in preventing withdrawal symptoms.

Recent Australian data indicate that antidepressants are overwhelmingly prescribed by general practitioners (91%), unchanged from 2007 to 2011.[4] Looi et al question whether evidence on antidepressant withdrawal symptoms from a UK National Health Service cohort is generalisable to Australia. There is no biological reason why withdrawal phenomena should differ between British and Australian patients. There is a growing body of international literature showing that patients can experience severe and prolonged withdrawal symptoms, particularly after long-term antidepressant use.[5,6]

Whether antidepressants should be continued long term and how to help patients who wish to stop taking antidepressants are important clinical questions. Reliable evidence supporting maintenance treatment is lacking, while there is evidence of harm.

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