Fatigue and general practitioners

Nijrolder and colleagues described the diagnoses they found during follow-up of patients presenting with fatigue in primary care.[1] Our study (prospective, cross-sectional, within a one-year period[2]) was performed to determine accompanying reasons for the encounter, symptoms, diagnostic procedures, recent diagnoses and therapeutic procedures in patients suffering from fatigue in a primary care setting. Fatigue was associated with acute infectious diseases of the respiratory tract, anemia, mental disorders, heart and circulation problems and nephropathies. The low rate of diagnoses at the initial consultation stated by Nijrolder and colleagues may be due to a watchful waiting strategy. Our investigation revealed that about 70% of the patients with fatigue were asked to see their general practitioner again. Watchful waiting seems to be a proper strategy after excluding cardiovascular problems and severe infections. This is supported by earlier investigations of Kenter and colleagues,[3] who found that fatigue is often a temporary story.

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For the full letter, go to: www.cmaj.ca/cgi/eletters/cmaj.090647v1#232962

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The big picture of medical transport

The report by Singh and colleagues[1] adds significantly to the broader discussion of regionalized health care and the risks of transporting patients to distant areas for care. In addition to the risks associated with the actual transportation of the patient, studies also need to address the issues faced by patients prior to "lifting off from home" and what happens at the "other end." Health care professionals seeking more advanced care for their patients often have to search for significant lengths of time before a receiving centre and team can be found. Once a receiving centre is identified, there are often further delays for a multitude of reasons ranging from the weather to the expertise of the transporting team. Such delays can make a difference to patients with serious problems. Understanding the fuller extent of these "transport issues" and the effects and costs that they have is really required.

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DOI:10.1503/cmaj.109-2051

Asthma in older adults

Asthma is frequently overlooked in the geriatric population, as in the present review by Meyer S. Balter and colleagues.[1] Asthma in older adults is associated with a significant number of hospitalizations and emergency department visits, which lead to substantial amounts of health care costs. Even when discovered, it is often undertreated.[2] The hallmark symptoms of asthma, including episodic shortness of breath, wheeze and cough, are nonspecific in older adults and are mimicked by other diseases, such as congestive heart failure, emphysema and chronic bronchitis, chronic aspiration, gastroesophageal reflux disease and tracheobronchial tumours. Several things must be taken into account when considering appropriate pharmacologic therapy in older patients, including poor inhaler technique, differences in pharmacodynamics and pharmacokinetics than in the younger population, diminished response to β_2-agonists, comorbidities, complex regimen, prohibitive cost and poor memory.

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For the full letter, go to: www.cmaj.ca/cgi/eletters/cmaj.080007v1#229616

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Correction

The "Letter from the Editor: No longer free for all"[1], published Nov. 24, said that access to reviews, analysis, practice, commentaries, humanities and supplements will be restricted to CMA members as of January 2010. In fact, that content will also be available to subscribers and pay-per-view readers.

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1. Hébert PC. Letter from the Editor: No longer free for all. *CMAJ* 2009;DOI:10.1503/cmaj.091910

DOI:10.1503/cmaj.109-2053