



Cultural Competence

Dear bpac,

You have featured two articles on “Cultural Competence” in the last two Best Practice Journals. BPJ13 had several articles on Maori issues and BPJ14 had the byline “Cultural Competence Series” above the article on Maori Mental Health.

I have been concerned that “Cultural Competence” is seen by many to be about Maori issues. The RNZCGP fuelled this concern by delegating its material on “Cultural Competence” to the Maori faculty and produced a document about “Cultural Competence” that made no mention of the use of interpreters. Of all the issues surrounding the care of people from other cultures, inability to communicate due to lack of shared language, surely has to go at the top of the list.

I have no problem at all with focussing on Maori health and really appreciated the focus on this. My problem is two-fold. The first is the invisibility of other cultural groups in this discourse; in fact many Maori view the issue as being about “Biculturalism”: Maori and the rest as if all of us who are not Maori are in some way the same.

The second, which is more subtle, is that I am a supporter of Irihapeti Ramsden’s thesis around Cultural Safety that argues that the best way to learn about the culture of a patient is to ask them....and that attempts to learn about “Maori” from sources other than the patient in front of you, risks stereotyping and compounding the problem of cross cultural care.

Language Line is now able to be used by GPs needing interpreting services at a cost of \$22 per consultation. An article about the dangers of using “Ad hoc” interpreters and how to use professional ones might be a useful addition to this series.

Regards

Dr Ben Gray,

Senior Lecturer

Department of Primary Health Care and General Practice, Wellington School of Medicine and Health Sciences

When discussing cultural competence we have deliberately focused on Māori given that this is where the greatest health inequalities exist and therefore where the greatest gains can be made. This focus is relevant given the New Zealand context and provides examples to which all clinicians can relate.

This is not to imply that all non-Māori are the same. We have emphasised that even within one ethnic group there may be different world views and beliefs and agree that clinicians must not generalise and stereotype patients. As New Zealand becomes more culturally diverse, clinicians need to develop increased sensitivity to the influence of different cultures on health care beliefs and practices.

The evidence of disparities in health care is significant and the responsibility for achieving better outcomes is clearly shared broadly across society. Bpac will continue to contribute through education, analysis and advice.

Metformin and folate

Dear bpac

We are in a tutorial discussing the latest bpac publication and we note that metformin is listed as inhibiting folate absorption. As metformin is very commonly prescribed it is important to know how much of a clinical issue this effect could be. Should all type 2 diabetics on metformin have a folate check and at what age and how often? Any clues about this?

Regards

Dr Logan McLennan

GP, Wellington

Chronic therapy with metformin is associated with decreased absorption of vitamin B12. As certain processes in the body are dependent on the presence of both vitamin B12 and folate, folate levels are also subsequently decreased.

People using metformin are therefore at an increased risk of vitamin B12 and folate deficiency. The extent to which vitamin B12 and folate levels are decreased during treatment varies between patients and length of therapy.

There are no clear guidelines on who should be checked and at what age, however it would be reasonable to monitor vitamin B12 status once a year in people taking continuous metformin, especially older people and those who have taken metformin for several years. Unexplained anaemia-like symptoms would also indicate that testing is required. It is not necessary to monitor folate status as well, as vitamin B12 will be indicative of a metformin-related deficiency.

People taking metformin could also be encouraged to include foods in their diet that are rich in folate and B12 such as leafy green vegetables, red meat or fortified foods.

Gargling with aspirin

Dear bpac

Is there any evidence that gargling with aspirin relieves the pain of a sore throat?

GP, Dunedin

Although a common remedy for sore throat, there is no evidence that aspirin gargles are clinically effective for this indication.

There are no relevant systematic reviews of the effectiveness of aspirin gargles for sore throat. One small study found that a preoperative aspirin gargle was better than placebo in reducing the incidence of postoperative sore throat. However aspirin gargle was not as effective as benzydamine hydrochloride (e.g. Difflam) gargle.¹

Despite the lack of evidence, most medical references advise that aspirin gargles can be tried for sore throat. Aspirin gargles should not be swallowed if other methods of pain relief are being used. In some cases, gargling with aspirin may cause irritation to an already inflamed throat. Aspirin should not be used in children under 16 years.

Other methods for relieving the pain of a sore throat include paracetamol, lozenges (or anything that acts as a demulcent e.g. honey) and warm drinks.

1. Agarwal A, Nath S, Goswami D et al. An evaluation of the efficacy of aspirin and benzydamine hydrochloride gargle for attenuating postoperative sore throat: A prospective, randomised, single-blind study. *Anaesth Analg* 2006; 103(4):1001-3.

Do you prescribe Amizide?

Dear bpac,

I am writing as Chair of the Medicines Adverse Reactions committee (MARC) to seek BPAC's assistance in ensuring wider recognition of an important safe and quality use of medicines issue related to Amizide.

Amizide is a combination of hydrochlorothiazide 50 mg and amiloride HCl 5 mg. This is a very old formulation which is not used often now, but there are a number of patients who have been on it for long periods. The inappropriately high dose of hydrochlorothiazide, compared with 12.5 - 25 mg in all other modern thiazide combinations, represents a potential risk for patients. There are case reports of hyponatraemia and hypokalaemia with this combination, particularly in the elderly and it is not an effective potassium sparing combination. The only other hydrochlorothiazide combination containing a dose of greater than 12.5 mg is Triamizide (25 mg + 50 mg triamterene) - both are marketed generics and still fully subsidised by PHARMAC.

Review of the CARM data base does not suggest a disproportionate number of reported adverse reactions compared to other thiazides, partly because new use of Amizide is low. Nonetheless, patients are still being admitted to hospital with hyponatraemia or hypokalaemia on this combination. It is likely that most of these cases are so well recognised that they are not reported to CARM. Although the real incidence of these adverse effects remains uncertain, there is an important practice principle when using thiazides long term – use the lowest possible dose to minimise risks such as gout, new onset diabetes and hypokalaemia. Hydrochlorothiazide should not be used in doses exceeding 12.5 mg daily. Bendrofluazide doses should not exceed 2.5 mg daily and lower doses such 1.25 mg daily are often adequate.

The risk of metabolic adverse effects associated with thiazides is dose related. Furthermore, any additional antihypertensive benefit from the use of hydrochlorothiazide doses of greater than 12.5 mg daily is outweighed by the increase in metabolic adverse effects. The MARC considers the Amizide formulation to be inappropriate, given current knowledge, and that its risks may out-weigh benefits because of the inappropriately high dose of hydrochlorothiazide, particularly in the elderly.

Sincerely,

Timothy Maling

Chair, MARC.



**We value your feedback. Write to us at:
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