

Screening change

Modern medicine and ongoing research have demonstrated time and time again that often what we believed was correct in the past is no longer valid. New evidence brought to us by current research enables us to change our practice accordingly and provide patients with updated medical therapies and advice.

We all agree that colorectal cancer (CRC) mortality cannot be ignored in a first-world country such as Canada. Colorectal cancer is not only treatable in its early stages, but is also preventable with different screening strategies such as fecal occult blood testing and colonoscopy. It is true that screening has potential harms and costs, but these will improve with implementation.

Can we continue to refute CRC screening using arguments from 40 years ago?¹ I do not believe that it is possible. For my part, I discuss the benefits and potential risks of different screening approaches with my patients, and initiate discussions about CRC screening in particular to increase awareness of this preventable cancer.

I do not think we do enough CRC screening compared with other developed countries, and instead depend too much on less expensive approaches that might not be as reliable.

—V. E. Ginzburg MSc MD CCFP
Thornhill, Ont
by Rapid Responses

Reference

1. Turcotte F. Should Canadians be offered systematic screening for colorectal cancer? No [debate]. *Can Fam Physician* 2008;54:505-6 (Eng); 509,511 (Fr).

Out of Africa

I was delighted to read the article about Dr Maskey's experiences as a hospitalist in the May issue of *Canadian Family Physician*.¹ I would like to draw attention to the fact that family physicians and general practitioners in sub-Saharan Africa are specifically trained for hospital work.

The concept of family medicine in some African nations is still underdeveloped. Most people are living in impoverished rural areas with little development and few or no medical personnel. The family physicians are still doing "everything": surgery, gynecology, obstetrics, orthopedics, ophthalmology, etc.

In Nigeria, family medicine education is based on the concept of training "specialist GPs" to function in district or rural hospitals in case there are no general surgeons, gynecologists or obstetricians, orthopedic surgeons, or otolaryngologists available. At least 90% of the time, these specialists are not available in district hospitals.

Family practitioners practising in remote communities in Australia also have these "added" generalist skills. The Australian College of Remote and Rural Medicine

has received accreditation to provide medical education, training, and professional development in the specialty of general practice. And the Royal Australian College of General Practitioners offers a Graduate Diploma in Rural and General Practice.

Family medicine in sub-Saharan Africa has yet to gain the respect it has in Canada and the United Kingdom. In Nigeria, in order to attract young doctors to family medicine, the government gave family physicians the status of hospital consultants to place them on par with their specialist colleagues. But the battle for optimal family medicine practices in Nigeria continues.

—Emmanuel M. Monjok MD
Houston, Tex
by Rapid Responses

Reference

1. Maskey JM. A chance of place and pace. Family physicians as hospitalists in Canada. *Can Fam Physician* 2008;54:669-70 (Eng), 672-3 (Fr).

Swallow your pride

I must comment on your otherwise excellent and enjoyable article on vitamin B12 in the April issue of *Canadian Family Physician*,¹ which repeats the fallacy that the only treatment for pernicious anemia is life-long vitamin B12 injections. In fact, there is high-quality evidence that—even in pernicious anemia—sufficient amounts of vitamin B12 can be absorbed orally when large enough doses are given. Absorption occurs by diffusion, even in the total absence of intrinsic factor.

Some experts recommend parenteral vitamin B12 for neurologic complications of B12 deficiency, and multiple parenteral doses to replenish the body stores. In symptomatic individuals, it is also reasonable to give 1 parenteral dose at the same time that you initiate oral treatment. However, in neither state is it necessary to continue life-long injection treatment. In individuals lacking intrinsic factor (or for any other form of malabsorption), the amount of B12 passively absorbed from 500 µg taken orally per day is equivalent to a 1000 µg injection per month.

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The daily recommended requirement of vitamin B12 is 2.5 µg. If 1% of a 500-µg dose is absorbed, the absorbed amount equals 5 µg (double the daily recommended requirement). I usually prescribe 1000 µg of vitamin B12 daily, which is more than sufficient and allows for the occasional missed dose. Once treatment has commenced, it is not necessary to check serum levels of vitamin B12. I have occasionally done so, and the levels are invariably in the upper physiologic range or even higher.

As a general practitioner, I often have to send this evidence to consultants who attempt to return my patients taking oral vitamin B12 to injection treatment. In an age of reduced patient and physician time, with financial strains on the health care system, this simple change to oral treatment can be beneficial.

Authors of a recent Cochrane review stated that "Vitamin B12 is rarely prescribed in the oral form in most countries, other than Canada and Sweden, where such replacement recently accounted for 73% of the total vitamin B12 prescribed. Possible reasons for doctors not prescribing oral formulations include unawareness of this option or concerns regarding effectiveness due to unpredictable absorption."²

—Ralph Jones MD CCFP
Chilliwack, BC
by Rapid Responses

References

1. Kannan R, Ng MJM. Cutaneous lesions and vitamin B12 deficiency. An often-forgotten link [case report]. *Can Fam Physician* 2008;54:529-32.
2. Vidal-Alaball J, Butler CC, Cannings-John R, Goringe A, Hood K, McCaddon A, et al. Oral vitamin B12 versus intramuscular vitamin B12 for vitamin B12 deficiency. *Cochrane Database Syst Rev* 2005;20(3):CD004655.

