My experience, along with that of Dr Tandeter, demonstrates how important it is for family physicians to screen all of their adult patients for sleep apnea, regardless of their body types, without waiting for some life-threatening development to prompt that screening. My personal physician has been screening all of his gout patients. He has reported to me that a large majority of those patients have subsequently been diagnosed with sleep apnea, even though neither he nor they previously suspected that result.

Sleep apnea is known to be very common, to have long-term, life-threatening consequences, and to be woefully underdiagnosed. It is important for family physicians to practise preventive medicine to achieve proper diagnosis and effective treatment before serious, irreversible consequences are incurred.

—Burton Abrams
Elkins Park, Pa

Reference

1. Tandeter H. Obstructive sleep apnea. A puzzle built in retrospect. *Can Fam Physician* 2009;55:74-5.

Government billing interferes with standards of care

While I might agree with Drs Montgomery and Sadler[1] that excisional biopsy is the preferred procedure for pigmented lesions, I would like to point out that provincial insurers (in Ontario) actively discourage this procedure by discriminating between malignant and nonmalignant lesions. If you know the diagnosis for certain (as with results from a punch biopsy), you can book your time and do the adequate excision with appropriate margins and marking and collect the fee. If you are uncertain of the diagnosis but go ahead with excisional biopsy with appropriate margins and marking and it comes out benign, you bill a substantially lower fee (the malignant fee code in Ontario requires pathology results). The fee differential in Ontario is $70.90 for a malignant lesion on the face versus $14.80 for a mole. If you are lucky and the lesion is premalignant (which has a narrow definition), you bill $53.20. All of these require the exact same amount of work and care.

Barriers to optimal care built into the billing schedules must be eliminated or most, like me, will still do punch biopsy before investing substantial time and effort to do the right thing!

—Ernest E. Hajcsar MD CCFP
Burlington, Ont

Reference

1. Montgomery BD, Sadler GM. Punch biopsy of pigmented lesions is potentially hazardous [letter]. *Can Fam Physician* 2009;55:24.

New tool for FPs

On behalf of the College of Family Physicians of Canada's Advisory Committee on Family Practice, I am pleased to draw your attention to our newest addition to the Primary Care Toolkit: "Key Principles and Values for Family Physicians in Primary Care Model Development." This is a Web-based resource that has been prepared by a working group under the leadership of Dr David Gass to address a question that arose during our discussions with physicians searching for family practice or primary care practice settings: What should I look for in order to be professionally satisfied with a new practice? This new resource lays the foundation for the underlying principles and values on which family practice is based. We are pleased to share this resource in "Appendix 9: Key Principles and Values for Family Physicians in Primary Care Model Development" of the Primary Care Toolkit at **www.toolkit.cfpc.ca/en/introduction/index.php**. Please do not hesitate to contact the Advisory Committee on Family Practice with any questions. We value your feedback.

—Rob Wedel MD CCFP FCFP
Chair, Advisory Committee on Family Practice

Treating chronic pain

I read with interest the dialogue "That sinking feeling. A patient-doctor dialogue about rescuing patients from fibromyalgia culture" in the November issue of *Canadian Family Physician*.[1]

In 2005, discouraged by the lack of improvement in the lives of my patients suffering from chronic non-cancer pain, I spearheaded a multidisciplinary team that included physicians, pain specialists, a nurse, physiotherapists, an occupational therapist, a psychologist, an exercise physiologist, and fitness trainers from the Kingston Family YMCA.

We developed a 12-week exercise and education program, Y-PEP, based on the chronic pain self-management program by Dr Sandra LeFort at Memorial University of Newfoundland in St John's.[2] Y-PEP sessions include concepts, such as pacing, problem solving, and setting

The top 5 articles read on-line at cfp.ca last month

1. **Practice:** Update on the Canadian Diabetes Association 2008 clinical practice guidelines (January 2009)
2. **Research:** Recruiting medical students to rural practice. *Perspectives of medical students and rural recruiters* (January 2009)
3. **Praxis:** The COPD Action Plan (January 2009)
4. **Commentary:** Antibiotics in acute exacerbations of chronic obstructive pulmonary disease (January 2009)
5. **Genetics:** Hereditary hemochromatosis (January 2009)

goals, and gently graded exercises, such as tai chi, yoga, and pool therapy.

This low-cost community-based program is now in its third year. We found that our registrants were as disabled at the outset as ill chronic renal failure patients! Those who completed the program had reductions in their depression scores, which correlated with reductions in the degree to which their pain interfered with their lives and increases in their functioning.

As well, qualitative interviews revealed themes of hope, social support, and coping skills that were associated with decreased depression, a shift to an internal locus of control, and increased assertiveness when communicating about pain. Participants indicated that these factors assisted with their pain management and enhanced their participation in meaningful occupations.[3]

After Y-PEP participation, 2 of my own chronic pain patients returned to work after many years of complete disability.[4] If you are interested in bringing Y-PEP to your own community, please contact me by e-mail at **rdubin@kingston.net**.

—Ruth E. Dubin MD PhD FCFP
Kingston, Ont

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1. Alghalyini B, Oldfield M. That sinking feeling. A patient-doctor dialogue about rescuing patients from fibromyalgia culture. *Can Fam Physician* 2008;54:1576-7.
2. LeFort S, Gray-Donald K, Rowat KM, Jeans ME. Randomized controlled trial of a community-based psychoeducation program for the self-management of chronic pain. *Pain* 1998;74(2-3):297-306.
3. King–Van Vlack C, Di Rienzo G, Kinlin M, Rehel D, Spermezan-Fecior C, Walker H, et al. Education and exercise program for chronic pain patients. *Pract Pain Manage* 2007;(7):17-27.

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4. Dubin R, King–Van Vlack C. *The trajectory of chronic pain: can a community-based exercise/education program soften the ride?* Poster presented at: 8th International Conference on Pain and Chemical Dependency; October 2008; Philadelphia, PA.

Corrections

In an effort to simplify the table appearing as part of Figure 1 in the "Update on the Canadian Diabetes Association 2008 clinical practice guidelines,"[1] an error was inadvertently introduced. The row on sulfonylureas should have included metiglinides; the comments about improved postprandial control and 3 to 4 daily doses only apply to metiglinides. Metiglinides improve postprandial control and require 3 to 4 daily doses, while sulfonylureas are associated with weight gain. The authors apologize for this error and any confusion it might have caused.

Reference

1. Bhattacharyya OK, Estey EA, Cheng AYY. Update on the Canadian Diabetes Association 2008 clinical practice guidelines. *Can Fam Physician* 2009;55:39-43.

The link to the electronic gestational age calculator provided in the Praxis article "The electronic 'pregnancy wheel,'" which appeared in the February issue of *Canadian Family Physician,*[1] will become inactive as of March 30, 2009. The calculator can now be accessed at **http://spreadsheets.google.com/ccc?key=prmMuvEba7LymhsNvYVzBMQ**.

Reference

1. Greiver M. The electronic "pregnancy wheel." *Can Fam Physician* 2009;55:169.