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Response

The letter from Drs Campbell and Abbass and our article[1] both serve as reminders to physicians to consider all of the important causes of chest pain, including GERD and psychiatric disease. We whole-heartedly agree with several important points in their letter. Anxiety disorders meeting *DSM-IV* criteria are common among patients visiting the emergency department for chest pain.[2] Optimal care would diagnose and manage anxiety at an early stage in order to reduce suffering and improve outcomes. We believe FPs have the expertise to provide a patient-centred approach to care that encompasses the range of physical and psychological issues involved in chest pain.

The complex interplay between the brain and the gut warrants additional emphasis. Studies show that people suffering with either chest pain or GERD will often have concomitant anxiety.[2,3] Furthermore, having an anxiety disorder does not immunize an individual against other causes of chest pain, including cardiac causes and GERD. In the same way that overemphasis on acid-related causes could distract our attention from the patients who have anxiety disorder, we must not overlook GERD or coronary artery disease in patients with panic disorder or other anxiety disorders. Comorbid conditions are common in patients with chest pain, and appropriate management is needed for both the psychological and physical components of their conditions.[2] The brain-to-gut and gut-to-brain connections are real and very important when assessing and managing GERD patients presenting with chest pain.[4,5]

If a patient's chest pain is caused by GERD, treatment with proton pump inhibitors can completely resolve symptoms and restore health.[6] It is not common to have this degree of success with treatments for the other causes of chest pain and comorbid conditions. Family physicians are well positioned by virtue of their skills and ongoing care to diagnose and manage both physical and psychological diseases associated with chest pain.[7] We are proud of the important role FPs play in the evidence-based management of chest pain, anxiety disorders, and depression.

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Cause of confusion

I read with interest Dr Gillson's letter in the January 2007 issue (*Can Fam Physician* 2007;53:29-30) regarding the North American tendency to confuse progesterone and progestogen and found myself in such violent agreement that I needed to inform him that this is not purely a North American phenomenon. The same confusion and fuzzy terminology is widely encountered in Ireland and the United Kingdom. This is surely just one example of the insidious effects of pharmaceutical marketing on our thinking, despite the fact that there is widespread belief that medical professionals are somehow immune to subliminal advertising!

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by e-mail

When the law calls

I am writing in response to the article by Dr Dalby in the January 2007 edition of *Canadian Family Physician* entitled "On the witness stand. Learning the courtroom tango."[1] Much of Dr Dalby's article will be very helpful to family doctors who are asked or called to give testimony; however, some statements in the article might mislead family physicians in the following areas: the definition of an expert in the context of Canadian law, the responsibility