Letters
Correspondance

Sleep apnea and gout

Like Dr Tandeter,[1] I am recovering from sleep apnea. Unlike him, however, I am not and never was overweight. In retrospect, I can deduce that my sleep apnea developed about 20 years ago, when I was 46 years old. The reason I can make that deduction is that was when I first experienced the severe pain of an overnight attack of gout. It was an unforgettable experience.

I recognized the connection between gout and sleep apnea about 15 years later when my sleep apnea was finally diagnosed and resolved—and my frequent bouts of gout ended permanently. Physiologic support for my observation comes from pulmonology journal literature dating back more than 20 years, which describes 2 physiologic mechanisms by which hypoxemia from sleep apnea can lead to gout flares. First, it causes hyperuricemia from cell catabolism, which culminates irreversibly in cellular generation of excess uric acid. Second, it causes hypercapnia and acidosis, which make the precipitation of uric acid from the blood as monosodium urate more likely.

Gout was not the only comorbidity that receded after my sleep apnea was resolved, although its recession was the most immediate. The other comorbidities were diabetes and atrial fibrillation. The atrial fibrillation had led to a transient ischemic attack, after which my sleep apnea was finally diagnosed.

As with Dr Tandeter, during my 15-year period with sleep apnea my wife noticed my loud snoring. At the end of that period, she realized that the breathing stoppages that she had also witnessed while I slept were a telltale sign of sleep apnea. But I never recalled experiencing excessive daytime sleepiness, which is why I never suspected sleep apnea. My recollection notwithstanding, I realize now that I am more fully awake during waking hours than I was when experiencing sleep apnea.

I don't use continuous positive airway pressure to prevent recurrence of my sleep apnea. Position therapy works for me—I never sleep lying on my back. After 18 months of sleeping with props to ensure that I didn't roll over onto my back, I am now trained to sleep that way always. How do I know that it works? I know from sleeping that way one night in a sleep lab, from my own measurements at home using a tape-printout pulse oximeter, and from the fact that I am gout-free.

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)