Approach to GERD

I read the article "Deprescribing proton pump inhibitors"[1] in the May issue of *Canadian Family Physician* with great interest. As a practising endoscopist I advocate for avoiding ongoing re-prescribing of proton pump inhibitors (PPIs) for patients with gastroesophageal reflux disease (GERD).

Farrell and colleagues[1] have successfully demonstrated evidence against the ongoing use of PPIs in GERD; however, they have not provided sufficient tools for primary care practitioners to assist patients with managing symptoms while not taking PPIs. In my practice I often see that when patients are not given effective education about GERD and elimination diets they become victims of different health marketing trends, which results in frustration due to failing at various diets. This leads them to return to the practitioner to request a PPI. Although there are many studies on dietary intervention in GERD, there is still no standard approach to a GERD diet. When studies such as those by Kaltenbach et al,[2] which was mentioned in the article,[1] and others[3,4] compare the effects of a GERD diet on GERD symptoms, they often compare similar but not the same approaches, and thus are not able to draw a clear conclusion on the effectiveness of a GERD diet. This leads to a lack of practical tools for practitioners to implement in patient care.

Farrell and colleagues also suggest that when a PPI and diet approach fail, a practitioner should ensure to test for and treat *Helicobacter pylori*.[1] I would disagree with this recommendation, as evidence of *H pylori* contributing to GERD is equivocal and even a reverse relationship has been demonstrated in several studies.[5-7] Moreover, the referenced study by Raghunath et al[8] has clearly indicated that the opposite is true, as the study found that the eradication group had an increased prominence of heartburn.

—Val E. Ginzburg MD CCFP
Toronto, Ont

Competing interests
None declared

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True reconciliation

I thank Dr David White, the College of Family Physicians of Canada (CFPC) President, for his May President's Message, "Indigenous health: time for action."[1] Dr White highlights some important actions by the CFPC in response to the Truth and Reconciliation Commission of Canada's 2015 calls to action[2]; for example, he points out the collaboration between the CFPC's Indigenous Health Working Group and the Indigenous Physicians Association of Canada in producing a fact sheet on discrimination and racism toward Indigenous people in the health care system.

As an Indigenous family physician, I hope the CFPC and the medical community might consider even further steps to address the Truth and Reconciliation Commission of Canada's calls to action. In 2012 the Government of British Columbia appointed Dr Evan Adams, a Coast Salish family physician, Deputy Provincial Health Officer for Aboriginal Health[3]; to this day, this is the only such position of its kind, in which Dr Adams has jurisdictional legal powers and can advocate for Indigenous people in British Columbia at the highest provincial level. This is very important. Indigenous people have long sought self-determination, and research has shown it to be a protective factor for health.[4] Subsequently, Dr Adams has become the Chief Medical Officer of the First Nations Health Authority in British Columbia. Interestingly, with the commitment to put Indigenous family physicians in positions of leadership, the people who identify as Indigenous in British Columbia have better health than other Indigenous people in Canada.[5]

I encourage the CFPC, among others, such as medical associations, medical regulatory authorities, health authorities, and provincial ministries of health, in sharing space with their Indigenous colleagues, allowing for a way of true reconciliation.

It is like Justice Murray Sinclair, Chair of the Truth and Reconciliation Commission of Canada, says,

"Reconciliation is not an Aboriginal problem—it is a Canadian problem. It involves all of us."[6]

—*Daniel McKennitt MD CCFP MPH*
Sandy Bay Ojibway First Nation
Treaty One
Turtle Island, Man

Competing interests
None declared

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Time off work

I disagree with Dr Karazivan admonishing the resident for not giving the patient the 3 weeks off work that the patient requested in the May Cover Story, "Thinking like a rebel."[1] Refusing a patient's request for time off from work has nothing to do with systemic power, inequities, or capitalism, as Dr Karazivan suggests. In fact, refusing a request for time off from work, in the absence of evidence to support the need for time off, is practising good medicine.

The Choosing Wisely Canada occupational medicine recommendation 1 is "Don't endorse clinically unnecessary absence from work."[2] The rationale for the recommendation includes the "substantial evidence to support the positive link between work and health (physical, mental and social health)."[2] Absence from work slows recovery and prolongs disability. Rather than giving time off the work, the physician should give restrictions that are "objective, specific, and listed only when absolutely medically indicated."[2]

Dr Karazivan asks who is winning by not granting a patient 3 weeks off work if that's what he or she is asking for. He concludes that the patient's boss is winning. In fact, by not granting 3 weeks off from work, the patient is winning.

—*Jordyn Lerner MD*
Winnipeg, Man

Competing interests
None declared

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Correction

In the article "Community-associated methicillin-resistant *Staphylococcus aureus* infection," which appeared in the July issue of *Canadian Family Physician,*[1] an error was inadvertently introduced in **Table 2**. The correct version of the table appears below.

Table 2. Treatment of outpatient SSTI in the era of CA-MRSA

SSTI	TREATMENT
Simple cutaneous abscess (in a low-risk patient not involving face, hands, or genitalia)	Incision and drainage alone; obtain culture
Purulent cellulitis (without abscess): treat for CA-MRSA if risk factors present	Tetracycline, trimethoprim-sulfamethoxazole, or clindamycin
Nonpurulent cellulitis (no exudate): treat for β-hemolytic streptococcus	β-Lactam antibiotic (cloxacillin or first-generation cephalosporin)

CA-MRSA—community-associated methicillin-resistant *Staphylococcus aureus*, SSTI—skin and soft tissue infection.
*A detailed management algorithm is available within the Infectious Diseases Society of America guidelines 2014 update on SSTIs.[74] All recommendations are level II evidence, adapted from the Infectious Diseases Society of America 2011 guidelines.[65]

Canadian Family Physician apologizes for this error and any confusion it might have caused.

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