

DIVISION CALENDAR



**ST GEORGE DIVISION
OF GENERAL PRACTICE**
41 Dora Street
Hurstville NSW 2220
Ph ~ (02) 9585 2044
Fax ~ (02) 9585 2144
Email ~ stgeorge@stgeorgedgp.asn.au
Web ~ www.stgeorgedgp.asn.au

MANAGEMENT COMMITTEE

Dr Angelo Mazzaferro

Chairperson

Dr Roslyn Ridgway

Vice Chairperson

Dr Alan Lawford

Treasurer

Dr Kypros Koutsoullis

Secretary

Dr Phillip Taplin

Dr Joy Mowbray

Committee

Dr Denis Smith

Hospital Representative

Ms Elizabeth Martin

Consumer Representative

STAFF

Dr Klaus Stelter

Executive Director

Joy Aldred

Division Office Manager
Practice Support Officer

Linden Harper

EPC Program Officer

Program Coordinator

Silvana Marangoni

Education Program Officer

Sponsorships/Memberships

Executive Assistant

Karen Christian

Population Health, Aged Care and
Immunisation Program Officer

Lesley Pullen

Community Liaison & Antenatal Shared Care
Womens Health

Sandra Johnston

GP Liaison Officer

Michael Russo

IM/IT

Exercise Physiologist

Mariam Faraj

Mental Health
Adolescent Health

Matthew Austin

Mental Health Nurse

Sue Coxon

QUM/NPS Facilitator

Raelene Elliott

Regional MAC
and Clinics Co-ordinator

Jenny Cooper

Practice Nurse Program Officer

Jenny Chan

Dietitian

Fernando Gomez

Clinical Psychologist

Andrew Szemenyei

Counselling Psychologist

Belinda Ivanovski

Clinical Psychologist

Maria Felicetti

Administration & Publication Co-ordinator

Date/Time	Venue	Event
-----------	-------	-------

PANDEMIC UPDATE

5 August

6:30pm Dinner
7:00pm Update
workshop

St George Research
& Education Centre
Cnr South & Montgomery Streets
KOGARAH

Pandemic Update

Topics & Presenters:

Genevieve Maguire RN-Infection control

Dr Phillipa Binns - Public Health Unit

Dr Klaus Stelter - GP Prespective

St George Hospital Representative - Flu Clinic

September

2 September

6:30pm light dinner
7:00pm-8:00pm
workshop

St George Division
Of General Practice
41-43 Dora Street
HURSTVILLE

**Medical Director Training
Workshop of GP's
Session 1: Overview &
Key Features**

9 September

6:30pm light dinner
7:00pm-8:00pm
Workshop

St George Division
Of General Practice
41-43 Dora Street
HURSTVILLE

**Medical Director Training
Workshop of GP's
Session 2: Letter Writer &
Recall/reminders**

16 September

6:30pm light dinner
7:00pm-8:00pm
workshop

St George Division
Of General Practice
41-43 Dora Street
HURSTVILLE

**Medical Director Training
Workshop of GP's
Session 3: MD & Chronic
Disease Management incl.
Immunisation**

TOTAL COST \$60 – FAXBACK RSVP

Note For Your Diaries 15th Annual General Meeting

23rd October

6.30pm Pre dinner drinks, 7.00pm Dinner

Conca D'oro Lounge
The Renoir Room
269 Belmore Road
Riverwood

ADVERTISING RATES

To place an advertisement or for further information contact the Division on 9585-2044, fax 9585-2144 or by email on stgeorge@stgeorgedgp.asn.au. The new rates, from July 2008, are:

Quarter page: \$150 + 10% GST

Please note that funds raised from advertising help pay for the production of this newsletter.
Advertising Disclaimer: Advertisements and links to websites where goods or services are advertised are not endorsements or recommendations and no responsibility or liability for their utilization is accepted by The St George Division of General Practice.



Safety... First!

Colleagues

The 10 July edition of Medical Observer carried a lead story: "The mental and emotional wellbeing of Australia's GPs is under siege ... with nearly 60% of doctors reporting 'troubling' to 'unmanageable' levels of stress .

You would not have to be an Einstein, to put forward the following reasons for such stress; pressure from an ever more demanding and litigious society, pressure from ever increasing demand for "services", pressure from the spectre [or is it sceptre] of Medicare Audits, pressure from a "new" breed of angry/disgruntled patients, covert threats [sometimes overt and carried out] from patients, trying to act as gatekeepers but copping the ire of patients, current issues like coping with swine flu without "equipment", pressure for ever more "education", financial pressures – and how about just plain exhaustion!!!

You will notice that left out from that list is the stress of our clinical work – the undifferentiated, often very ill patient, to sort out in 15 minutes [or less if other patients are "hanging from the rafters" in your waiting room] – all of a sudden the "clinical" stress is overwhelmed by "bureaucratic processes" of modern medicine!

Pandemic (H1N1) Update

**5 August 2009/
RSVP VIA FAXBACK**

**For all resources, templates
and current information
please refer to the Home
Page of our website at
www.stgeorgedgp.asn.au**

**Alternatively, call the team
on 9585 2044 for Practice
visits and faxed information.**

The Division tried to set up a GP Health & Wellbeing program some years ago but it sort of withered on the vine – if there is enough feeling out there perhaps we could resurrect it again.

To gauge your feeling about such a program perhaps you could fax the Division via the FAXBACK SHEET accompanying this Newsletter.

In the meantime; keep safe, keep well and don't let the b..... get you down.

Dr Klaus Stelter
Director

inside this edition:

REFERRALS	PG	2	•	OF	SUBSTANCE/BALINT	GROUP	PG	3						
ATAPS	PG	4	•	ST	GEORGE HOSPITAL	PG	5	•	WOMENS	HEALTH	PG	6		
BREAST	SCREENING	PG	7	•	ADVERTISEMENTS	PG	8	•	DEPARTMENT	OF	NUCLEAR	MEDICINE	PG	13

GP Beware (1)

There are many things that the GP has to watch out for – but one not often thought of as a “trap” is as was headlined in Medical Observer last year as:

Beware the referral – referring patients to another practitioner – registered or otherwise – has legal ramifications.

Yes, according to Medical Defence Advisors [Dr Sara Bird and Dr Paul Nisselle] we GPs can be held liable for a “poor outcome” as a result of one of our referrals.

Dr Paul Nisselle says “your [the GP’s] direct negligence might have been in the act of referral ...patients could be inclined to assume that the person they are being referred to is endorsed by their doctor...”

Dr Sara Bird quotes a 2001 Supreme Court case involving a patient referred to a chiropractor for treatment of neck pain. That chiropractic “intervention” severely aggravated the patient’s condition and the chiropractor and the referring GP were found equally liable – the chiropractor for his negligent “treatment” and the GP because the chiropractic treatment was contraindicated [and hence the GP should not have given a referral].

While the problem is “worse” with unproven complimentary and so called alternative practitioners, liability can occur in any referral if the GP has failed to:

- **keep good medical records**
- **to review patient’s documentation**
- **perform a physical examination**
- **to consider if referral is appropriate**

One gets the impression that while not many cases get to court, that may be more good luck than good management and how many of us blithely give referrals [often under pressure as in the dental scheme] where the indication is dubious [as to not qualifying for a Care Plan] and if the outcome is “disastrous” we may get a double whammy from the Medicare Audit and the Court, in case of negligence.

GP Beware (2)

There would not be too many GPs who would not have been caught out by being duped to supply opiates to patients who have an addiction problem and come in with the most innovative stories so as to procure more supplies.

The scenarios are well known now – unknown patient, last appointment, story or crumpled letter from a doctor out of town, dreadful pain, “only you can help me”, “no I am immune to all other analgesics” etc etc.

A helpful publication called “Of Substance” – a national magazine on alcohol, tobacco and other drugs [available to GPs on www.ofsubstance.org.au] has a story entitled Pill Popping – misusing pharmaceuticals which reports:

Australia has experienced a marked increase in opioid use in the past five to ten years ... but also increases in prescription drug-related hospitalisations and deaths.

Oxycodone use has increased four-fold over ten years both legitimately; for chronic pain but report says that “Several studies suggest that while opioids can provide initial benefits [in chronic non-malignant pain] this does not necessarily equate with significant long term benefits” and oxycodone has also become a favourite in the illicit drug culture as ‘hillbilly heroin’.

But the report recommends that we should be moving away from classifying patients as ‘legitimate’ pain patients or ‘bad doctor shopping’ patients and adopt a “universal precaution model” which:

- Recognises that long term opioid use can be associated with problems in a proportion of all patients
- Encourage prescribing practices that aim to prevent such problems

The article goes on to suggest to reduce the restriction on GPs to be able to prescribe buprenorphine for chronic pain and opioid dependency – in the same way that they can currently prescribe other opioids.

However, at present if you want to prescribe for chronic pain patients beyond two months you must get authorisation from the Pharmaceutical Services Branch of NSW Health.

Lifestyle Change: Managing Stress & Good Timing

Behaviour change at the best of times is challenging so you can only imagine how difficult it would be if you feel stressed. Although in my infant stages as an Exercise Physiologist I have observed a direct negative correlation between stress and behaviour modification i.e. patients who report low stress levels achieving good health outcomes in comparison to those with high stress. It would not be unusual to categorise the GP in the latter so at this point please reflect on how many times have you attempted an exercise program or healthy eating plan and succeeded long term?

To initiate behaviour change it is useful to assist the person with stress management, which will include light intensity exercise and healthy eating. The focus is on reducing stress in order to minimise the patient's perceived effort to initiate and sustain lifestyle change, which will build confidence and long term success.

Revisiting motivational interviewing and the stages of change, the GP must determine if the person is ready to change. I would like to extend this by suggesting that the GP should differentiate between ready to change and "able" to change. The patient may be ready, but when you explore their ability you discover that the timing is poor and the patient will struggle to implement changes.

Patients need to develop confidence in their ability to implement lifestyle changes. It is essential that patients understand that making lifestyle adjustments without altering their environment is setting themselves up to fail. A simple analogy would be forcing a square peg into a round hole, if you push hard enough it will slightly go in, but after a few attempts it becomes too hard and you stop. Examples of red flag comments may be:

- I should be able to fit in exercise
- If I try hard then I should be able to do organise some time
- I know I have to do eat better and exercise

Michael Russo
Exercise Physiologist

Inaugural Balint Group

Eight GPs met for the first Balint Group in July – they have elected to get CPD points and so will meet monthly until Year's end.

Feeling our way, under the stewardship of Clinical Psychologist Fernando Gomez we came away feeling we had achieved what the Balint Group's objectives are:

"A group of GPs who meet regularly and discuss clinical cases. The focus is on the psychological aspects of General Practice and particularly the doctor-patient relationship. The group is a supportive setting in which GPs can explore the human side of General Practice, add a refreshing new dimension to their work, learn new skills and avoid burnout."

Fernando reminded the group at the start about confidentiality and that the purpose was not to problem solve, but more to reflect on what the doctor [and patient] might be feeling during difficult consultations and how those feelings could interfere with best outcomes.

This particular group is now closed but if there is demand/interest we will look to opening another.

Apparently in Europe Balint Groups for GPs are a requirement for accreditation – that is not the case here but it highlights that GPs do need an opportunity to sometimes "debrief" in relation to difficult consultations.

Physical Activity & Depression

Physical activity can be an effective supplement to treatment in mild and moderate depression, achieves a short term reduction in anxiety and may also prevent the relapse of depression. Explain to your patients with depression that "the less you do, the worse you feel" and that regular physical activity can help relieve mental tension and muscular tension and may lift mood.

Please review the "Physical Activity & Depression" insert published by the Heart Foundation.

Introducing: **Andrew Szemenyei** Have You Ever Wondered Why Babies Smile So Early?



Around age 6 weeks for most. Some research now suggests a baby's smile activates pleasure receptors in the mother's brain (and may I say also the father's). Just when many mums are reaching exhaustion due to lack of sleep and constant hard work, something happens which gives them joy and the desire to continue responding to their baby in a caring and interactive fashion. Nature's design for a healthy attachment between the infant and its key caring/protective figures begins to take form, and helps to create the environment for optimal physical and emotional development.

Mothers with post-natal depression (about 10% of mothers giving birth) find this difficult, experiencing persistently low moods, 'flatness', lack of enjoyment, and lacking in responsiveness to their baby. They often feel stressed, anxious, guilty and self-critical over perceived failures in their role. Poor sleep and subsequent difficulties with energy levels, memory and concentration are common. Mothers occasionally have thoughts of running away, harming themselves or their baby, usually (though sadly not always) without any intent to act. They may experience a difficult post-birth recovery, other health issues, as well as chaotic circumstances such as other kids at home, relationship stress, perhaps domestic violence between the adult partners.

At times such risks exist for the mother and baby that the treating professional is compelled to report to Community Services (DoCS) and/or Mental Health Services. This can be difficult with mothers who are already stressed and vulnerable. I always take time to explain the protective, helpful intent of my actions, which usually helps.

The good news is that treatment can be of great benefit, and offers a good opportunity for collaborative work between the family GP and the Psychologist. Research suggests both medication and psychological treatment can be effective, although it is not clear that a combination of the two is superior. However, as it is difficult to make predictions about the best choice for any individual, it does not make any sense to force patients to just keep to one, or discontinue one in order to start the other. Treatment can take time, so it is good for the professionals involved to stay in contact, particularly in view of the long-term, supportive relationships many GP-s have with their patients, as opposed to the relatively short-term interventions I provide.

In my own clinical experience, it is not unusual for the two treatments to complement. Medication may lift the patient's moods, and help them engage in therapy. Some patients do excellent work in therapy, but still struggle with specific symptoms, such as an enduring flatness with depression or the physical discomfort of anxiety/panic. We discuss medication, and at times they need to move past the idea that such a trial would be indicative of a failure on their part. They then visit their GP (or in some complex cases a Psychiatrist), try some medication which helps to manage or resolve their symptoms (much to the delight of everyone involved). Life moves forward, and the patient can re-engage with nature's design for themselves and their family.

Andrew Szemenyei is the Peri-Natal/ Child & Family Psychologist at St George DGP. Referrals (Medicare Item 2710) under ATAPS for mothers experiencing post-natal depression and anxiety, as well as for children with emotional difficulties up to the age of 12 with their families.

Hospital News



The Latest News from St George Hospital

Swine Flu Update |||||

Advice re Swine Flu is that we are now at the PROTECT Phase with swabbing of all suspected cases no longer required. Patients who fit case definition should be managed according to NSW Health guidelines for at risk patients. GPs are still asked to manage patients unless they are "clinically unwell with co-morbidities likely to need admission" – these can be sent to the re-established St George Hospital Flu Clinic, open 11am to 7pm seven days a week/or ED after hours.

Anti-Coagulation Clinic |||||

The anti-Coagulation Clinic runs 8-9 am every Thursday within the Outpatients Department of the St George Hospital. Clients are initially reviewed in the Haematology Clinic and then referred to the anti-Coagulation Clinic for monitoring and management.

New Rheumatologist for St George Outpatients |||||

Dr Bill GIANNAKOPOULOS has commenced at the Outpatients Department at St George Hospital. Referrals to his clinics can be made via the Outpatients Department.

Physiotherapy Hand treatment clinics at St George Hospital |||||

Please note that these clinics are not diagnostic clinics and not to be confused with the Sydney Hospital Hand Clinic

The clinic provides a "physiotherapy treatment service" for conservative and post surgical management of both acute and chronic hand conditions.

- A referral letter is requested; written by the referring doctor and faxed to the Physiotherapy Department, St George Hospital (F) 9113 3075.
- Alternatively, the patient may bring the referral letter to the Physiotherapy Department between the hours of 8-4.30 Monday to Friday to book an appointment

COMMON CONDITIONS TREATED:

- Fractures and dislocations
- De Quervain's Tenosynovitis
- Carpal Tunnel Syndrome
- Dupuytren's Contracture

- Trigger Fingers
- Tennis/Golfer's elbow
- Mallet injuries

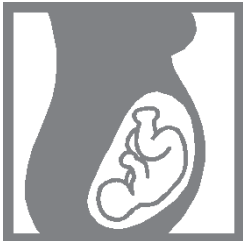
SERVICES PROVIDED:

1. **Assessment** of hand and upper limb conditions, and identification of potential problems that can delay recovery. This includes the assessment of:
 - Pain & Swelling,
 - Fractures
 - Scarring
 - Decreased ROM and joint stiffness
 - Muscle length and strength
 - Neurological testing and sensory mapping
 - Functional tasks
2. **Patient education regarding the injury sustained and the expected course of treatment.**
3. **Selection and implementation of appropriate treatment techniques including:**
 - Pain management
 - Wound & scar management
 - Exercise prescription
 - Plaster and fibreglass casting For acute fractures and other soft tissue injuries
 - Thermoplastic and commercial splinting
 - Electrotherapy Including ultrasound, laser and paraffin wax baths
 - Manual therapy Including passive stretching, joint mobilisations, deep and soft tissue massage, trigger point therapy
 - Desensitisation and function re-training
4. **Design and implementation of home exercise programs.**
5. **Close patient monitoring, follow-up care and evaluation.**
6. **Appropriate referrals to team members and outside resources** (eg. Community support such as CRAGS)

SENIOR PHYSIOTHERAPISTS for "physio hand treatment":

Korina Horne & Michele Chim (02) 9113 2163
Email: korina.horne@sesiahs.health.nsw.gov.au
michele.chim@sesiahs.health.nsw.gov.au

If you have any questions regarding services at St George Hospital or are having issues which are impacting on patient care please don't hesitate to contact GP Liaison Sandy Johnston on 0407 210 197 and she will endeavour to source a solution



Women's Health Update

Lesley Pullen

Women's Health Clinic Open 2 days per week!

As you are aware the Division has opened a free Women's Health Clinic at Rockdale Community Health Centre so as to provide an alternative for GPs to refer their female patients.

The Registered Nurse at the clinic is offering women a Pap smear, breast check and pelvic floor assessment, and is especially interested in seeing women

- who come from a culturally and linguistically diverse (CALD) background;
- or who have never had a Pap smear;
- or who have not had a Pap smear for over 4 years
- and who live in the Rockdale and Kogarah Council areas

The Clinic is now open two days per week – Wednesdays and Fridays and we would like to invite you to refer your female patients to the Nurse for their Pap smears and breast checks. You may like to introduce the subject by asking each woman you see when they last had a Pap smear.

Women may only access this service with a referral from their GP. The referral form needs to be faxed to the Division where staff will call your patient to make an appointment. If an interpreter is needed we can organise one at the time of booking.

Pathology for this clinic is managed by Douglass Hanly Moir who will send you the results to maintain continuity and follow-up with your patient.

Resources are available on our website at: www.stgeorgedgp.asn.au click "Division Programs" then "Women's Health". Scroll down to the resource links.

Should you have any questions regarding this initiative, please call at the Division on 9585-2044

SESIAHS – Area Wide Breastfeeding Leaflets Are Now Available For Health Professionals to Access for Their Patients

The Area Lactation Group and the health promotion service of SESIAHS have been working on producing area wide breastfeeding leaflets. They are finally completed and up on the internet for GPs and Practice Nurses to access. The website link is http://www.sesiah.health.nsw.gov.au/publications/health_Promotion/index.asp.

Breastfeeding Leaflets available are:

- Breastfeeding tips for new mothers
- Expressing and storing breast milk
- Increasing your supply of breast milk
- Preparing artificial formula feeds, sterilising bottles and teats
- Supplementary feeds
- Mastitis
- Use and care of dummies
- Using nipple shields
- Weaning or suppressing lactation
- Breastfeeding after breast surgery
- Breast care when your baby has died

The Use of Thermography to Detect Breast Cancer

Some women are known to have been loudly advocating the use of thermography rather than mammography to detect early breast cancer. This is an uninformed view and not one which is supported by the scientific organisations mentioned below.

Breast thermography is a technique that produces "heat images" of the breast by measuring the temperature of the skin. The rationale for thermography in breast imaging is that the skin overlying a breast cancer can be warmer than that of surrounding areas.

Studies have shown that a tumour has to be several centimetres in diameter before it can be detected by thermography. According to several reviews there is no current scientific evidence to support the use of thermography in the early detection of breast cancer. Overall, studies have shown that thermography produces an abnormal result on too many women who do not have cancer, and it misses cancers that are known to be present in other women.

Screening mammograms have the ability to detect a breast cancer at a much smaller size, and therefore to reduce deaths from breast cancer. Less than 50% of breast cancers detected by mammography screening have an abnormal thermogram.

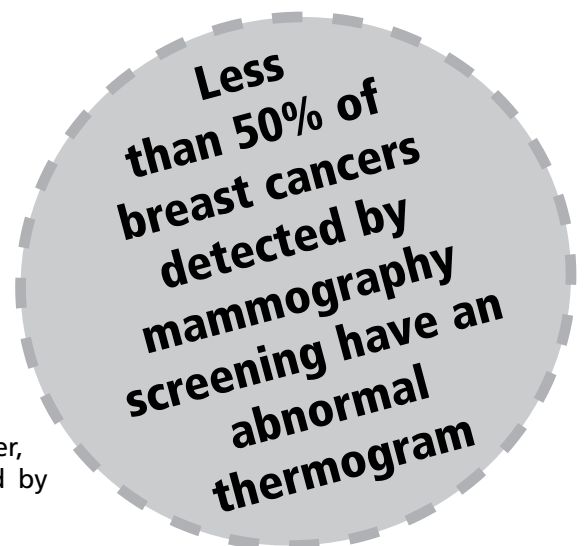
The following organisations support the use of mammography and do not support the use of thermography:

- BreastScreen Australia
- National Breast Cancer Centre
- Royal College of Radiologists of Australia & New Zealand
- American Medical Association
- American Cancer Society
- Cancer Research UK
- Mayo Clinic, USA
- Australian Therapeutics Goods Administration
- Medicare Australia

Of the range of techniques in use for the detection of breast cancer, mammography is currently the only examination that is supported by objective randomised clinical trials for screening and diagnosis.

References:

1. Homer, MJ 1985: "Breast Imaging: Pitfalls, controversies and some practical thoughts" Radiological Clinics of North America 23:459-471
2. Martin JE 1983: "Breast imaging techniques, mammography, ultrasonography, computed tomography, thermography and transillumination" Radiological Clinic of North America 21: 149-153
3. BreastScreen Australia. Statement on use of thermography to detect breast cancer, vol. 2007: Australian Government Department of Health and Aging
4. American Medical Association. Thermography Update H-175-988, vol. 2007: American Medical Association Website, 2007
5. Australian Medical Association. Position Statement on Breast Cancer Screening, vol.2007: Australian Medical Association Website, 2007
6. BreastScreen South Australia. Position Statement 1 – The use of thermography to detect breast cancer. BreastScreen SA Website, October 2007
7. American Cancer Society. Thermography (Thermal Imaging), vol. 2007: American Cancer Society Website, 2007
8. Cancer Research UK. Thermography of "heat mapping": Cancer Research UK Website, 2007
9. National Breast Cancer Centre. BreastScreen Australia Program Statement on the use of thermography to detect breast cancer, vol. 2007: National Breast Cancer Centre Website, 2007



Counselling And Therapy Services



**MEETING THE MENTAL HEALTH NEEDS
OF THE COMMUNITY**

CBT - Schema



- 20 years of clinical experience
- 15 years as senior clinician
- 5 years director of a private psychiatric facility
- Individual, couple and family counselling
- Services covering the full diagnostic spectrum

English - Greek

When experience matters

**Bob Tsapilis, Psychologist, MAPS,
APS College of Clinical Psychologists
Mobile: 0425 807937, Provider Number: 4069931W**

**Shop F17-18 Level 3, Centro Roselands,
Roselands Drive, Roselands, NSW, 2196**

PRACTICE STAFF EDUCATION



"A big thank you"

The St George Division of General Practice would like to thank **Allison O'Hara**, Vaccine Account Representative, and the team from

CSL Biotherapies

for their support of the Practice Nurse and Staff Education program. The team from CSL have agreed to sponsor two St John Ambulance CPR meetings for your practice staff.

CSL Biotherapies are proud to support the Practice as a whole.



Dr Bill Giannakopoulos

B.Sci. (Med), M.B. B.S. (UNSW), Ph.D (UNSW), F.R.A.C.P

CONSULTANT RHEUMATOLOGIST

Senior Academic Research Fellow (Immuno-rheumatology)

St George Public Hospital

Outpatients Department (Immunology)

Prince William Wing, 1 South St Kogarah 2217

Phone No for bookings: 9113 2513 or 0415671024 (mobile)

Provider No:2148967B



Dear Colleagues

I would like to take this opportunity to introduce myself as a new, consultant General Rheumatologist in the St George area.

I am interested in treating and managing, in close collaboration with the patient's GP and other relevant specialists, all facets of rheumatology practice, including rheumatoid arthritis, lupus, gout, other types of inflammatory arthritis, osteoarthritis, fibromyalgia, back pain, neck pain etc.

I have a special interest in the antiphospholipid syndrome, having successfully completed my PhD, and now continue to undertake research with Professor Steven Krilis in this area. I have published extensively first authors papers in leading international peer-reviewed journals such as Arthritis & Rheumatism and Blood on the pathophysiology, diagnosis and management of this condition.

I look forward towards working with you in the future.

Kind regards

Dr Bill Giannakopoulos



The Adolescent with Back Pain

Clinical History

A fourteen year old boy presents with a six week history of low back pain. The pain was intermittently present, but now is present at rest. Examination revealed a limited range of back motion with no localised tenderness. The patient's main complaint is that he is unable to bowl at cricket as fast as he would like.

Scan Findings

The planar bone scan (Figure One) demonstrates a typical fracture of the pars interarticularis and this is confirmed on the tomographic or SPECT images in Figure Two.

Discussion

Back pain in an otherwise well adolescent athlete may be caused by many conditions but the condition to exclude is a pars interarticularis fracture as this may contribute to nearly 50% of cases of back pain in athletes. The fracture is thought to be due to repetitive hyperextension of the posterior elements of the spine. The fast bowler is the typical candidate for a pars fracture, but other sports such as gymnastics, football and weightlifting are also implicated. Not only is the diagnosis important, but there is evidence that early intervention may improve long term outlook. Untreated this condition predisposes the patient to a spondylolisthesis and chronic back pain. Unfortunately there is no universally accepted treatment for this condition. Most authorities would recommend stopping the sport, analgesia and physiotherapy focussing on flexion activities, hamstring stretching and core strengthening. The condition can take up to nine to twelve months to fully resolve.

Conclusion

The test of choice for the diagnosis of a pars fracture is a bone scan. Plain radiographs and MRI are relatively insensitive in the diagnosis of this condition. CT has a better sensitivity than plain radiographs and MRI but cannot differentiate an acute from an old fracture.

Reference

Cassas KJ et al. Childhood and Adolescent Sports-Related Overuse Injuries. *Amer Fam Phys* 2006; 73:1014-22

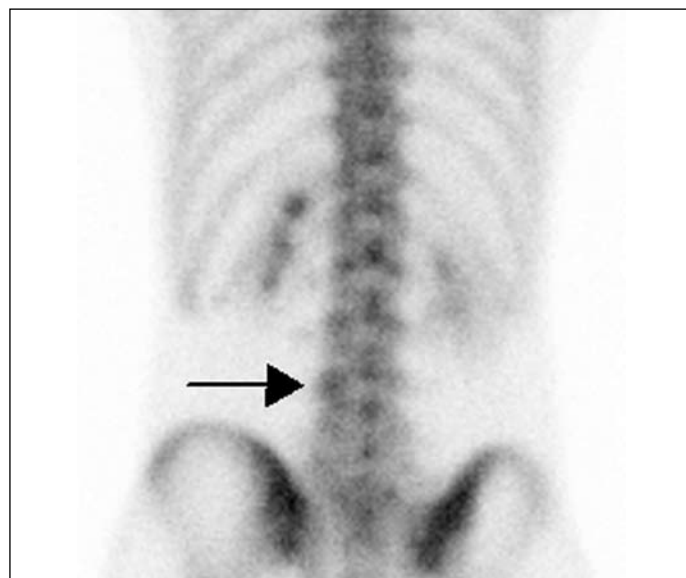


FIG. 1 Posterior view of lumbar spine bone scan with focal uptake in posterior aspect of left L4 vertebra.

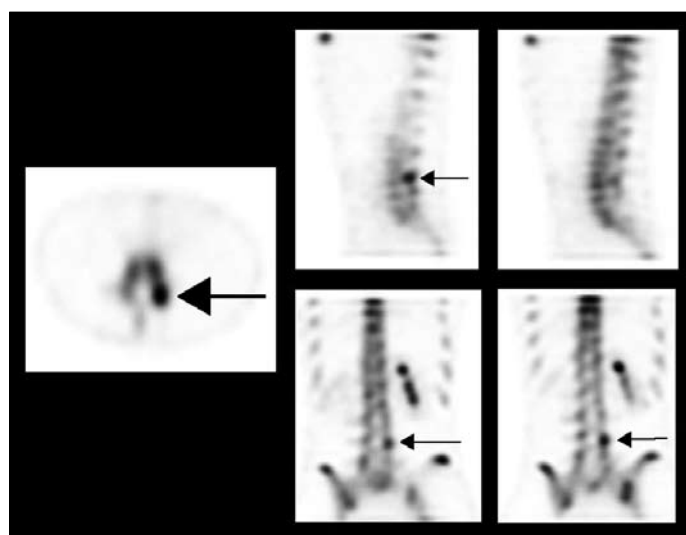


FIG. 2 Tomographic (SPECT) images showing focal uptake in pars interarticularis region of left L4 vertebra.

Case Study submitted by

Patrick Butler

Department of Nuclear Medicine,
St. George Hospital.