The Sydney siege: courage, compassion and connectedness

To the Editor: Raphael and Burns highlighted the strong police response to the hostage situation in Sydney in 2014.1 Diversionary devices, such as the flash-bang grenades used in Sydney, have been increasingly used to distract and disorientate people in civilian hostage and riot situations internationally. While not intended to cause permanent damage, there are risks associated with their use.

Flash-bang grenades deflagrate using a powdered blend of aluminium, magnesium and ammonium perchlorate, which generates a spontaneous explosion. When initiated, illumination is produced through oxidation of the components, resulting in heat exceeding 38°C, a blast reaching 180 decibels and a brief flash of 1–6 million candela (up to 600 million lux) within a distance of about 1.8 m.2

The intense flash results in temporary bleaching of the photoreceptors in the eye. Ocular injury can occur if the flash-bang grenade explodes at close range, with possible thermal or mechanical damage. Other more powerful devices, producing a similar intensity of unidirectional light, have resulted in vision loss similar to that seen with laser weapons.2

Temporary hearing loss and aural pain results from a single or multiple blast of loud noise between 140 and 170 decibels. Damage to the sensitive structure of the inner and middle ear can result in hearing loss and tinnitus.3 Perilymphatic fistula of the inner ear may occur, necessitating immediate assessment and possible surgical treatment.4

Premature deflagration can also cause injury to the operator.5 As these devices continue to be used in civilian situations, it is important to remain aware of any potential hazards, to both the operator and bystanders.

Ocular injury can occur if the flash-bang grenade explodes at close range

Hoskin et al

Missing malaria? Potential obstacles to diagnosis and hypnozoite eradication

To the Editor: Bradbury and colleagues highlight some important challenges in managing Plasmodium vivax malaria when appropriate diagnostics and therapeutics are lacking.1

Their article, prompted by one of the authors acquiring P. vivax in Solomon Islands, should also prompt consideration of how these problems affect the populations of countries where our cases of imported malaria originate. The authors warn of increasing risks to Australians because of greater overseas travel. However, this is not actually happening here in Australia, where nationwide notifications have fallen dramatically in recent years — probably reflecting less exposure of travellers to endemic malaria as a result of significant global improvements in malaria control.3,4

Solomon Islands provides a good example of this — with Australian and international support, reductions of >90% in malaria morbidity over the past 20 years have led to the tantalising possibility of complete elimination by 2030. However, P. vivax is problematic. In South Pacific populations, >50% of cases arise from hypnozoite relapses, which constitute the major drivers of ongoing transmission.5

Primaquine, recommended for routine case management, is rarely used in Solomon Islands, owing to nationwide unavailability of testing for glucose-6-phosphate dehydrogenase deficiency. A suitably cheap, accurate, temperature-stable point-of-care test is urgently needed, as is ongoing research to determine the best way to deploy antirelapse therapy in this setting.

Successful elimination of malaria in Solomon Islands and neighbouring countries would be a historic achievement for the health of the peoples of our region, and it would also pay a dividend for Australia’s own public health and biosecurity.

Karunajeewa et al


Successful elimination of malaria in Solomon Islands and neighbouring countries would be a historic achievement for the health of the peoples of our region, and it would also pay a dividend for Australia’s own public health and biosecurity.

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Getting the levers right: a way forward for rural medicine

TO THE EDITOR: We agree with the points raised by Kamerman in his erudite article.1 There are, however, two things that should be mentioned.

The first is that Townsville and Gundagai do not have the same Australian Standard Geographical Classification — Remoteness Area (ASGC-RA) classification: Townsville is categorised as RA3 (outer regional Australia), whereas Gundagai receives the less remote classification of RA2 (inner regional Australia). This magnifies the absurdity of the current classification situation even further.

The second is that not only would the general practitioner copayment policy have led to practices deciding against taking on registrars, but it would also have had an even greater potential for practices to decide against accepting medical students. Although the proposed Medicare rebate freeze will not have the immediate impact on undergraduate and vocational training that the copayment would have had, the net effect will ultimately be very similar.

Placement in rural general practices forms a key part of our medical student training and is a major factor in the success that we have had to date in our graduates choosing both generalist and rural career pathways. An unintended consequence of the copayment policy could have been to derail these positive outcomes with a stroke of the pen. We predict that, as the impacts of the Medicare rebate freeze take effect, enough practices will eventually decide to withdraw from training to have a significant negative impact on training programs and, ultimately, the primary health care workforce.

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A systematic approach to chronic heart failure care: a consensus statement

TO THE EDITOR: We commend Page and colleagues for their comprehensive statement on chronic heart failure (CHF) care.1 However, we wish to highlight an important omission to the discussion regarding telemonitoring.

There is Level 1 evidence for the use of telemonitoring as part of CHF management.2 Currently, telehealth is a major strategic item on the agenda of the federal Department of Health.3 Telehealth and telemonitoring can be the best options for Australians with CHF who do not have access to multidisciplinary or specialist heart failure care for reasons of carer responsibility, geography, socioeconomics, cultural and linguistic diversity, frailty, immobility or complexity of illness. To provide truly consumer-focused CHF care, options need to be available to all patients equally.4

We believe an opportunity has been missed in this consensus statement, particularly in regard to the poor access to multidisciplinary and specialist CHF care services in Australia.5 Although the evidence base for the use of telehealth in CHF care and management is still evolving, we now have a significant body of evidence demonstrating effectiveness in improving CHF outcomes.2

We agree with the authors that future research should consider the role of telehealth. However, we recommend that this research should be in the form of translation, implementation and integration of telehealth-based CHF care within the Australian health care system, to overcome current unresolved inequities.

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TO THE EDITOR:

Call time on alcohol advertising in sport

To the Editor: In handing down the 2014–15 Budget, the Australian Government announced the closure of the Australian National Preventive Health Agency (ANPHA), effective from 30 June 2014. It now remains to be seen whether the ANPHA’s comprehensive review of alcohol advertising regulation in Australia, including its draft recommendations for greater protection of children and young people exposed to alcohol advertising, will remain.

As a starting point, the ANPHA recommended that an exemption be removed from the Commercial Television Industry Code of Practice which allows direct advertising of alcohol products on free-to-air television before 8.30 pm as an accompaniment to live sport broadcasts on public holidays and weekends. If this recommendation were taken up by the government, it would significantly reduce young people’s exposure to alcohol advertising.

A wealth of evidence shows that frequent exposure of the young to alcohol marketing increases the likelihood of early initiation to drinking, higher consumption among those already drinking, and heavy drinking in the long term. Sporting events on television are extremely popular among young people in Australia, but exposure to alcohol advertising while watching these reinforces a close relationship between alcohol and sport.

Worryingly, young people’s exposure to alcohol marketing through televised sport now extends well beyond the ad breaks. In a recent study commissioned by Cancer Council Victoria, researchers at the University of Wollongong found that, of all alcohol marketing in the broadcasts during the major football code finals, most exposure came through vision of fixed signage around the stadium and integrated advertisements (live announcements, pop-ups and banners, and broadcast sponsorship announcements). Governments must strengthen regulations to protect children and break the nexus between alcohol advertising and sport.

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Firearms, mental illness, dementia and the clinician

To the Editor: In their recent article in the Journal, Wand and colleagues suggest that the medical profession should play a more active role in the regulation of firearm licences held by older Australians. However, the authors underestimate the rate of firearm ownership in Australia by a factor of 1000 when they state that 3.9 per 100 000 people held a firearm license in 2001. In reality, about three-quarters of a million Australians held a firearm licence in 2001.

While the reported vignettes seem compelling enough, the authors’ recommendations need...
some scrutiny. Almost 15% of the population are aged over 65 years, yet these older people commit about 3% of the roughly 250 homicides per year. Further, only about 15% of Australian homicides involve a gun. Hence, the potential number of lives saved by the measures they suggest can only be tiny.

In contrast, the downside of their recommendations might be significant. First, obligations on doctors to play a more active role in firearm ownership might deter some patients from seeking medical care. Second, even if people were not deterred from seeking health care, more active involvement by doctors in firearm regulation would come at the opportunity cost of ordinary medical care — care that could be focused on common and lethal medical conditions.

Firearm control in Australia has been singularly successful. While it may be the case that firearm involvement by doctors in firearm ownership might be significant. First, obligations on doctors to play a more active role in firearm ownership might deter some patients from seeking medical care. Second, even if people were not deterred from seeking health care, more active involvement by doctors in firearm regulation would come at the opportunity cost of ordinary medical care — care that could be focused on common and lethal medical conditions.

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Competing interests: I have given evidence in coronial proceedings into deaths that involve firearms.

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3 Firearms Act 1996 (NSW).


7 Hastings G, Sheron N. Alcohol marketing: grooming the next generation: children are more exposed than adults and need much stronger protection. BMJ 2013; 346: f1227.