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## Train GPs to provide good sexual health care

Congratulations on the *BJGP* editorial in the July issue!<sup>1</sup> Anything that raises awareness among GPs of the need for targeted opportunistic chlamydia screening can only be a good thing.

I am a British vocationally trained GP and I became interested in sexual health (that is, genitourinary medicine [GUM]) when I did a term at Mortimer Market Centre GUM clinic in London during my GP training. Due to a fundamental difference in training in Australia and the UK, I moved to Sydney to train in sexual health after finishing GP vocational training and working as a locum.

To give them their credit, the Australian authorities have always recognised the key role that GPs have to play in the sexual health of the nation, and have encouraged them to both train in sexual health and deliver it on a daily basis to their patients in their own surgeries. Hence, GPs here are encouraged to diagnose, treat, and follow up sexually transmitted infections (STIs). Contact tracing here is the responsibility of the doctor who ordered the test. Obviously complex cases will be referred to the sexual health clinics, but many cases could be resolved within primary care.

There are several local and national bodies running training courses and programmes tailored to the specific needs of GPs. I have been training with the Australian Chapter of Sexual Health Medicine since 2001, and they have had no problem accepting my GP background and qualifications. Contrast that with the approach of the UK Royal College of Physicians (RCP) regarding higher training in GUM — you must have the MRCP or MRCOG to start. Once I complete my training I will be dually qualified.

The UK does have something to learn

from the Australian model. Encouraging and empowering GPs to deliver sexual health care is the way to go. Any GP should be able to manage an uncomplicated case of gonorrhoea or chlamydia. GPs in Australia often manage syphilis, and there is a specific group of GPs in Sydney and Melbourne who provide holistic care for HIV-positive patients, including antiretroviral prescribing in all its complexity.

My point is that, as your editorial points out, in the UK 'the whole sexual health service seems to be a shambles'.<sup>2</sup> This is due to a mixture of: underfunding and under-resourcing; neglect; lack of planning; mushrooming bureaucracy; indifference from those in senior management in the health service at national and local/trust level; failure to make reliable, more efficient, patient-friendly new technology testing methods more widely available and used; and a large increase in the number of patients seeking to attend GUM clinics, be it because of increased awareness, increased testing in the community, or increased incidence of bacterial STIs. If UK GPs were encouraged and given the opportunity to attend appropriate training, and then supported at a local and national level, more patients with sexual health problems would have these attended to in the community, hence taking off some of the pressure on GUM clinics.

Having worked as a GP in the UK, I believe that GPs have the skills and the ability to manage many patients with sexual health problems in primary care, if given the appropriate training and support. This training should not only involve the existing DRCOG, DFFP and DipGUM; there should be specific GP-tailored government and health service sponsored courses, programmes, clinical attachments and so forth if substantial progress is to be made in the care of the nation's sexual health.

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## Fast-track cancer diagnoses

The results of Cornford *et al*'s<sup>1</sup> qualitative study effectively highlighted the stark contrast in priorities between patients wanting an urgent appointment to reassure them that they don't have cancer, and the specialists who wish to diagnose as high a proportion of cancer cases as possible. With a commitment to the patient's biopsychosocial wellbeing we are as GPs, once again, somewhere in the middle.

We initially wondered if patient recruitment was biased by self-selection. Those who responded may have been the most anxious, harbouring the strongest feelings about a timely diagnosis, hence effectively being an unrepresentative sample. This observation however, leads to a new hypothesis.

Are those patients who are found to not have cancer on the 2-week wait system, on the whole, better educated, more health motivated, more aware of their rights, more empowered in the GP consultation setting, and more anxious? If this is the case, then have we unwittingly created a two-tier system in which, apart from cases with obvious cancers, we are facilitating a service that reassures the worried well at the expense of all cases that are presenting outside the 2-week wait criteria,<sup>2</sup> and whose outcomes may be adversely affected by a longer wait.

Given the above hypothesis, the quotation from one GP who admitted using the 2-week wait system for patients who didn't fit the criteria, 'in case they go to the back of a long queue'<sup>1</sup> may prove particularly ironic — it may well be this type of behaviour that is turning the 'fast track' into a traffic jam.

Cornford *et al* make a strong case for reviewing cases where patients are 'inappropriately' fast tracked, and for a greater focus on the characteristics of patients who persuade their doctor to use the fast track. We look forward to presenting some data in due course.

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## Screening for type 2 diabetes

I wish to report the results of a screening project for type 2 diabetes performed over a 10-month period in our practice of 9700 patients. Patients presenting to the practice were screened opportunistically for type 2 diabetes if they showed two or more of the following risk factors, using a protocol based on an Australian screening study: aged >40 years, obesity, family history of type 2 diabetes, hypertension, atherosclerosis (coronary heart disease, cerebrovascular disease, or peripheral vascular disease), previous abnormality of glucose tolerance including gestational diabetes, ethnic predisposition, or polycystic ovarian syndrome.<sup>1</sup>

Patients were screened by random or fasting venous glucose, and those with blood glucose of  $\geq 5.6$  mmol/l were intended to have an oral glucose tolerance test. Of the 271 patients, 130 (48%) had an initial blood sugar of  $\leq 5.5$  mmol/l. Of the remainder, 91 patients (33.6%) proceeded to have oral glucose tolerance tests; 44 (16.2%) had

normal results, 27 (10.0%) had impaired fasting glycaemia or impaired glucose tolerance, and 20 (7.4%) had results within the diabetic range. A further three patients were diagnosed as diabetic on high random blood sugars alone.

Some 47 (17.3%) patients did not proceed to have glucose tolerance tests; in 24 cases this was due to administrative failure. Three patients declined to have the test due to the inconvenience, nine patients were tested for diabetes using an alternative method, and in 11 cases the GP decided not to proceed with further investigation for clinical reasons.

Overall 8.5% of patients screened had type 2 diabetes and a further 9.6% had impaired glucose tolerance, or impaired fasting glycaemia. The clinical workload and demand for appointments was manageable: on average only nine oral glucose tolerance tests were performed every month, and many of the random blood sugars were taken simultaneously with other recommended annual screening blood samples.

Further modification of the protocol is suggested, so that patients in some clinical situations are tested by fasting glucose and haemoglobin A1c (HbA1c) measurement rather than by oral glucose tolerance test.<sup>2</sup> Allowing some flexibility in interpretation of random blood sugar results according to the prandial state of the patient may also restrict unnecessary glucose tolerance tests.

This project demonstrates a feasible method for screening for type 2 diabetes and its precursors.

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## Jury service is bad for your health

Much has been written in the press about air passengers developing deep venous thromboses (DVTs) following long-haul flights. As a result of these reports of 'traveller's thrombosis' and several untimely deaths, those flying for over 4 hours are advised to take prophylactic measures, which include ensuring good hydration, restricting alcohol and caffeine intake, and regularly carrying out simple leg exercises including occasional walks during travel.<sup>1</sup> Those at particularly high risk are encouraged to consider using graduated elastic stockings and taking a single dose of aspirin or low molecular weight heparin before travel.

We recently came across a 47 year-old female hospital cleaner, with a body mass index of 32 but no other risk factors, who developed a calf DVT 2 days after completing 2 weeks of Crown Court jury service. This involved sitting for an average of 6 hours each day with a 45-minute lunch break which, towards the later stages of the trial, was also spent sitting while deliberating over the verdict. A small twist in the tale is the fact that 10 weeks prior to starting the jury service she had undergone two long-haul flights, each lasting 9.5 hours. It would be difficult to ascertain which events were the most contributory to the development of the venous thrombosis, but current evidence suggests that, in cases of traveller's thrombosis, the symptoms usually develop within 4 days of the flight and certainly within 2 weeks.<sup>2</sup>

Studies have shown that the main effect of prolonged sitting, and certainly a significant factor in the association between air travel and venous thrombosis, is venous pooling in the calf.<sup>3,4</sup> In addition to these haemodynamic responses, measures of rheologic changes in venous blood during prolonged sitting show that 2 hours of quiet sitting can increase thrombotic tendency locally in the leg, but not systemically.<sup>5</sup>

The patient has subsequently been informed that she may be required for further jury service. This being the case, then she should certainly be advised to take appropriate prophylactic measures. We feel that in any situation