Letters

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The global primary care crisis

January's Editor's Briefing[1] and the accompanying editorial by Darran Foo and colleagues[2] accurately diagnose the difficulties facing primary care. From the perspective of the NHS we might add fragmentation of working practices, leading to discontinuity of clinical care and difficulties for doctors, marked variation across the system in ways of working, and in quality of care and, in all sectors, less than inspiring management and leadership. In the UK the way that social care is funded and organised is nothing short of a national scandal.

The remedies for this very complex crisis must include not just more and better-targeted funding derived from increased taxation, but a complete rethink of how the NHS shows its staff that they are valued, rather than exploited, and a whole-system, long-term (and ideally cross-party) strategy for health and social care. Some of this could be achieved relatively rapidly by improvements in remuneration for low-paid workers and improved working conditions and amenities for all staff. Any impact of training more doctors will not be felt until far into the future, and the NHS has a dismal record in successful whole-system redesign. This makes the suggestions by Foo and colleagues of particular interest – a mechanism to identify, disseminate, and assimilate good practice at a manageable level. The Integrated Care Systems in the UK could provide a framework for doing this. Learning from success is a more appealing and relevant approach to system change than waiting for years for the (often unhelpful) results of large-scale health services research trials.

In all countries economies are damaged by ill health in the population, including in the healthcare workforce. Interventions that lead to better outcomes and are either cost-neutral or cost-saving deserve attention and investment.

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Who is your doctor?

Many patients simply don't know. If we are to realise the ambition of the Health and Social Care Select Committee, to provide *'continuity to all patients as much as possible'*,[1] we need to overcome current barriers and ensure patients know who their doctor is.

Many practising GPs (especially younger GPs) lack experience of relational continuity of care and fear that continuity metrics will be just another stick to beat GPs with. We need to change the narrative through widespread education. Only then will younger colleagues realise that continuity makes the job easier and more enjoyable.

The myth that continuity of care can only be delivered by 5-days-a-week working has led to intergenerational conflict. This has been debunked – GPs in Norway work 3–4 days[2] per week in their practice. In England, submissions to the Health and Social Care Select Committee show that continuity can be achieved with part-time working[1] by spreading working days across the week. Health Foundation research found 61% of patients will wait to see their preferred GP.[3] I work in a personal list practice and 'Who is your doctor?' is asked and reinforced throughout the patient journey.

Access models foisted onto primary care are weakly evidenced and need revaluation. Norway recently evaluated their national personal lists scheme (covering 4.5 million patients over 20 years) showing hard end points (fewer hospital admissions and lower mortality) and demonstrated a dose–response relationship.[2] We need to trust the evidence. Continuity is no longer just a nice idea.

The shortage of GPs mean we need to use them as efficiently as possible. Relational generalist care is the GP's 'scalpel' and should be front and centre in all our practices, primary care networks, and integrated care boards. To do this we must create the environment for GPs to flourish (ideally in partnerships) and keep them in the same community for as long as possible (most benefits >15 years).[2] Pensions and estates are relatively fixable problems, and should be urgently remedied. Then we can get to a place nationally where most patients can easily answer the question – Who is your doctor?

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Jacquet erosive dermatitis in an era of 'going green'

An 8-week infant male presented to paediatric dermatology with a 1-month history of a deteriorating perianal rash.

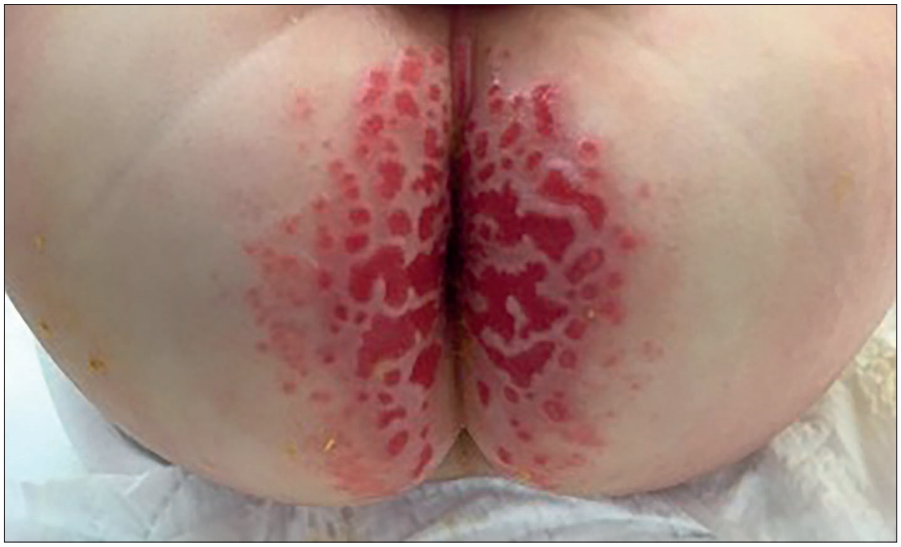

Figure 1. Perianal ulceration, classical of Jacquet erosive dermatitis.

Since birth, he had been unsettled and requiring hourly nappy changes because of loose, frequent bowel motions. He was exclusively breastfed.

Examination revealed symmetrical well-demarcated erythematous perianal erosions, typical of Jacquet erosive dermatitis (JED) (Figure 1). JED is a severe irritant dermatitis caused by prolonged contact with moisture and faecal enzymes. Despite the dramatic appearance, education on nappy use, barrier ointments, +/− a moderate topical steroid typically promote complete healing within weeks. The presented case was complicated by cow milk protein allergy (CMPA), symptoms of which settled with exclusion of dairy from the mother's diet.

The move from re-usable to absorbent disposable nappies had made JED extremely rare and increasingly unfamiliar to the new generation of dermatologists and GPs alike. With the ever-growing culture of 'eco-parents' combined with a surging prevalence of CMPA,[1,2] it is important we don't forget this diagnosis just yet!

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Patient consent

The patient's parent gave consent for the publication of this letter and its image.

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Lymphadenopathy following COVID-19 vaccination: a wake-up call from case reports

Enlargement of axillary, supraclavicular, or cervical lymph nodes following vaccination with COVID-19 mRNA vaccines is more frequent than initially reported, with a rate reaching up to 16% following the second dose of the Moderna mRNA vaccine. Although vaccine-related lymphadenopathy is most often a benign, self-resolving phenomenon, a few cases or B-cell- or T-cell-derived lymphoma were reported in the literature. There are also reports of clinico-pathological features suggestive of lymphoma but which ultimately proved to be caused by a non-malignant condition such as Epstein–Barr infection, extrapulmonary tuberculosis, or histiocytic necrotising lymphadenitis (Kikuchi–Fujimoto disease). So far, these isolated observations did not receive much attention in the medical community as the causal relationship with the vaccine administration was not established. On the other hand, they raise concerns in the lay public, especially among patients with similar experiences.

Although these individual stories do not allow drawing conclusions about a causal relationship between mRNA vaccination and the course of lymphoid malignancies, we may speculate that in occasional cases transformed lymphocytes are stimulated to expand by the strong immunoinflammatory environment elicited in lymph nodes by the mRNA vaccines. Whether or not such hypothesis is confirmed, treating physicians in charge of patients with post-vaccination lymphadenopathy should be reminded to consider in due course the possibility of an underlying or coincidental malignant disorder, as previously recommended in this journal.[1] This is important to prevent detrimental diagnostic delays, unjustified patient's psychological stress, or inadequate treatments.

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