

All letters are subject to editing and may be shortened. Letters should be sent to the BJGP office by e-mail in the first instance, addressed to journal@rcgp.org.uk (please include your postal address). We regret that we cannot notify authors regarding publication. Letters not published in the Journal will be posted online on our Discussion Forum. For instructions please visit: <http://www.rcgp.org.uk/bjgp-discuss>

Editor's choice

An end to depression in primary care?

I enjoyed Moscrop's essay.¹ As a GP Trainee in the early 70s with an interest in the psychological I was taught to distinguish between endogenous depression (no evident trigger, serious, chronic, more likely to respond to antidepressants) and reactive depression (for example, triggered by bereavement, relationship breakdown, or job loss, and less likely to respond to antidepressants). Inspired by the works of Michael Balint and Colin Murray Parks I tried to offer a listening ear to troubled patients in long appointments at the end of normal surgery times. There were inevitable disappointments, such as the newly-widowed lady who came to see me weekly over several months who plaintively asked on her last visit 'So am I not getting any pills?' An early addition to my Patient's Unmet Needs list.

Mike Thirlwall,

Retired GP, Minton, 91 Sheerstock,
Haddenham, HP17 8EY.
E-mail: thethirlwalls@btinternet.com

REFERENCE

1. Moscrop A. An end to depression in primary care? *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X654669.

DOI: 10.3399/bjgp12X658142

On your bike!

Thank you to Annie Elkins for an entirely convincing article on the benefits of cycling as a GP.¹ A solid evidence-based argument for incorporating regular cycling in to the working life of a busy GP is well presented. I can add to the impetus behind this message by reporting that cycling has massively boosted my enjoyment of my working day. Cycling to work every morning leaves me feeling invigorated on arrival, and travelling home is a fantastic way to unwind. If you are considering taking up cycling during your working day, the challenge that you

will face is that of establishing an entirely new routine that may involve changing clothes at work, showering at work, buying specialist rain gear, and finding somewhere safe to park your bike. Establishing the routine that works for you takes time. Perseverance and lateral thinking on ways to achieve a routine that suits you will pay incredible dividends. Annie Elkins suggests purchasing a pooled practice car for home visits. Can I add the suggestion of a pooled practice bicycle that all staff can use for running errands and attending to house calls?

Kieran Kennedy,

GP, Lecturer in Medical Education, School of Medicine, Room 203, Cumberford Building, Clinical Science Institute, National University of Ireland Galway.
Email: kieran.m.kennedy@gmail.com

REFERENCE

1. Elkins A. On your bike! *Br J Gen Pract* 2012; 62(602): 482.

DOI: 10.3399/bjgp12X658151

Predicting risk of bladder cancer in the UK

We were interested to read the paper by Shephard *et al*¹ on the clinical features of bladder cancer in primary care, as we have previously published a paper² in the *BJGP* where we reported on symptoms associated with renal tract cancer (of which around 80% were bladder cancers) in primary care. Both studies evaluated the risk or positive predictive value of symptoms for detecting cases of cancer, and both used UK primary care databases, but the study designs were different with Shephard *et al* using a case-control approach while we used a cohort design.

A key finding of both studies is that haematuria is a strong predictor of bladder/renal cancer, with a stronger association at younger ages. Indeed we reported that around three-quarters of renal cancer cases had reported haematuria before their diagnosis. Both

studies also found at least a doubling of risk in people consulting with abdominal pain. A strength of our study design was that we were able to combine the risks associated with the different symptoms and clinical features with the established risks associated with smoking, into an algorithm that can predict absolute risk in individuals presenting with symptoms. We also accounted for the steep increases in risk with age and for different risks in men and women, since rates in men are at least three times higher than in women. Crucially we validated this algorithm in a separate cohort of patients, and found that it discriminated extremely well between cancer cases and the remainder of the cohort (ROC values of 0.95 in men and 0.91 in women). The 10% of patients with highest risks contained 87% of all renal cancers diagnosed within 2 years. It is unclear how many cancer cases would be detected using the approach of Shephard *et al*, nor is there any validation on an external dataset which is an essential step needed to determine whether the results are valuable.³

Carol Coupland,

Division of Primary Care, University of Nottingham, University Park, Nottingham.
E-mail: Carol.Coupland@nottingham.ac.uk

Julia Hippisley-Cox,

Division of Primary Care, University of Nottingham, University Park, Nottingham.

Financial Disclosure Statement

JH-C is professor of clinical epidemiology at the University of Nottingham and co-director of QResearch, a not-for-profit organisation that is a joint partnership between the University of Nottingham and EMIS (leading commercial supplier of information technology for 60% of general practices in the UK). JH-C is also director of ClinRisk, which produces open and closed source software to ensure the reliable and updatable implementation of clinical risk algorithms within clinical computer systems to help improve patient care. CC is associate professor of medical statistics at the University of Nottingham and a consultant statistician for ClinRisk.

REFERENCES

1. Shephard EA, Stapley S, Neal RD, *et al*. Clinical features of bladder cancer in primary care. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X654560.
2. Hippisley-Cox J, Coupland C. Identifying patients with suspected renal tract cancer in primary care: derivation and validation of an algorithm. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X636074.
3. Altman DG, Vergouwe Y, Royston P, Moons KG. Prognosis and prognostic research: validating a prognostic model. *BMJ* 2009; **338**: b605.

DOI: 10.3399/bjgp12X658160

Steam inhalation therapy

I think the conclusion of the article *Steam inhalation therapy: severe scalds as an adverse side effect*¹ is excessively restrictive.

I do not know how 'steam inhalation therapy' is administered in the Netherlands, but I know practice in Britain has changed in the last four decades. We no longer use Nelson inhalers.

Many patients inhale over a washing-up bowl of boiling water, which brings in risks of transporting water from kettle to bowl to accessible table. I recommend either the use of a mug-full of boiling water, or the less-risky 'hot beverage', that certainly appears to reduce the risks in handling and in the total quantity of thermal energy if there is a spill. Alternatively, I recommend 'steaming' in a bath or shower of normal bathing temperature, this is substantially less than boiling, and should not induce more scalds than the ordinary weekly ablutions.

I disagree with the article's conclusion that there is no evidence of therapeutic benefit. There is a huge amount of anecdotal evidence for its therapeutic efficacy, in ENT and chest medicine in hospital as well as in general practice. I have never seen a scald from steaming; I have seen many from hot drinks: should we ban drinking?

David Church,

GP, First Aider, mid-Wales.

E-mail: bryntegywyn05@btinternet.com

REFERENCE

1. Baartmans M, Kerkhof E, Vloemans J, *et al*. Steam inhalation therapy: severe scalds as an adverse side effect. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X652328.

DOI: 10.3399/bjgp12X658179

Over-reliance of D-dimer in isolation to exclude venous thrombosis should be avoided

The shift to primary care expected in the initial 'diagnostic' management of cases of venous thromboembolism is indeed welcome. A recent article in the *BJGP* highlighted the role of D-dimer in reducing referrals for radiological imaging.¹ However, one of the messages that needs to be stressed in this context is the importance of clinical probability scoring system. It is important that the primary care physicians do not over-rely on the D-dimer, and clinical evaluation should be considered as the first step. Reliability on the D-dimer in isolation can have problems especially since there is evidence in the literature for thromboembolic episodes occurring in the context of normal D-dimer.^{2,3}

There are several possible explanations for a normal D-dimer even in the presence of venous thromboembolism. The levels of D-dimer increase in the circulation due to the breakdown of the fibrin-bound clots. Very often, individuals present with symptoms of lower limb thrombosis many days after the onset of symptoms. The clot breakdown in these cases may have ceased by the time they arrive for medical attention and the result would be a normal D-dimer. Second, in the patients who receive anticoagulation treatment sometimes before the hospital assessment is undertaken (patients who have problems with transport, or from the hospice, started on anticoagulation empirically), inhibition of clot lysis can cause normal D-dimer. This phenomenon has been noted to occur within 24 hours after receiving heparin therapy.⁴ It is also important to bear in mind that a normal cut-off of D-dimer is arbitrary and may not be applicable to every individual, since the clot-breakdown capacity varies between individuals. This is exemplified by the report in pregnancy of deep vein thrombosis and normal D-dimer.³ Last, there is the issue of wide variability between many different D-dimer assays.⁵ Each caregiver should take into consideration the appropriate cut-off suited for the assay and setting before

they can attribute a level useful in exclusion of thrombosis.

In summary, there is no alternative to good clinical assessment in the exclusion of venous thromboembolism and D-dimer level is only a useful adjunct.

Jecko Thachil,

Consultant Haematologist, Central Manchester University Hospitals NHS Foundation Trust, Oxford Road, Manchester, M13 9WL.

E-mail: Jecko.Thachil@cmft.nhs.uk

REFERENCES

1. Plüddemann A, Thompson M, Price CP, *et al*. The D-Dimer test in combination with a decision rule for ruling out deep vein thrombosis in primary care: diagnostic technology update. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X641645.
2. Kutinsky I, Blakley S, Roche V. Normal D-dimer levels in patients with pulmonary embolism. *Arch Intern Med* 1999; **159**(14): 1569-1572.
3. To MS, Hunt BJ, Nelson-Piercy C. A negative D-dimer does not exclude venous thromboembolism (VTE) in pregnancy. *J Obstet Gynaecol* 2008; **28**(2): 222-223.
4. Couturaud F, Kearon C, Bates SM, Ginsberg JS. Decrease in sensitivity of D-dimer for acute venous thromboembolism after starting anticoagulant therapy. *Blood Coagul Fibrinolysis* 2002; **13**(3): 241-246.
5. Goodacre S, Sampson FC, Sutton AJ, *et al*. Variation in the diagnostic performance of D-dimer for suspected deep vein thrombosis. *QJM* 2005; **98**(7): 513-527.

DOI: 10.3399/bjgp12X658188

Eosinophilic oesophagitis: a clinical update

I would like to thank you for the recent clinical intelligence article on eosinophilic oesophagitis.¹ As a current GPVTS working in ENT I found this clinical update very informative and relevant to my work. Interestingly only a few days after reading this article we admitted a 17-year-old young man complaining of a food bolus sensation following eating chicken earlier in the day. He was normally fit and well, and of note did not suffer with any atopic conditions. He was managed initially with medical therapy, however, after some initial improvement his symptoms deteriorated and the time between consumption and regurgitation of water progressively shortened.