

supervision while in the low resource country. For our OOPes who go to KwaZulu/Natal, we have a former senior GP educationalist who is able to visit them and supply some in-country support. Importantly, we also provide individual debriefing for returning OOPes to help with their re-integration into the NHS.

The sparsity of opportunities that Franey *et al* describe within GP schools is, I think, due to the perceived disruption of GP rotations in a short 3-year training programme. I would strongly argue that this a very small price to pay for the definite learning experiences for these trainees, who are high flyers and potential clinical GP leaders of the future, whether in the UK or overseas. We would encourage all GP schools to promote these OOPe placements, particularly in low resource countries.⁴

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REFERENCES

1. Franey C, Munir S, Seo H, Pettigrew L. The postcode lottery of GP training: Time out of programme. *Br J Gen Pract* 2013; **63**: 431.
2. Crisp N. *Global health partnerships: the UK contribution to health in developing countries*. London: Department of Health, 2007.
3. Hollister C. Out of programme experience (OOPe) in the developing world: how does it benefit GP training? *Educ Prim Care* 2012; **23**: 204–207.
4. Main P. Other times, other places: out of programme experience (OOPe) during GP specialty training — a preliminary report. *Educ Prim Care* 2013; **24**(5): 383–387.

DOI: 10.3399/bjgp13X675359

Diagnosing somatisation in adults in the first consultation

My only caveat to Wilson and Mann's article on medically unexplained symptoms¹ would be the use of the word 'stress'. I use this term very frequently, simply because my patients seem to identify with it easily and recognise the implied medical connotation. As with all things in general practice, I suspect that adequate and appropriate empathy will balance negative implications.

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REFERENCE

1. Mann B, Wilson H. Diagnosing somatisation in adults in the first consultation: moving beyond diagnosis by exclusion. *Br J Gen Pract* 2013; **63**: 607–608.

DOI: 10.3399/bjgp13X675368

Cardiovascular safety of non-steroidal anti-inflammatory drugs

The Medicines and Healthcare Products Regulatory Agency have directed that diclofenac is now contraindicated in patients with congestive heart failure (New York Heart Association classification II–IV), ischaemic heart disease, peripheral vascular disease (PVD) and cerebrovascular disease, due to the increased risk of arterial thrombosis.¹ Patients on diclofenac should see their GP at their next routine appointment to be switched to an alternative treatment.¹

We carried out an audit in an urban general practice of 13 000 predominantly white patients in Yorkshire to establish the number of patients affected by these recommendations and the subsequent impact on GP workload.

We identified 933 patients with one or more of the diagnoses recognised as contraindicating the use of diclofenac. Four hundred and eighty patients had ischaemic heart disease alone of whom 21 had been prescribed diclofenac in the last 12 months, with 10 on repeat prescription. Thirty-three patients had congestive heart failure alone of whom only one had been prescribed diclofenac (not on repeat prescription). Sixty-one patients were diagnosed with PVD alone; four had been prescribed diclofenac of whom one required a repeat prescription. One hundred and ninety-three patients had a diagnosis of cerebrovascular disease alone; 11 had been given a prescription of diclofenac, six on repeat prescription. One hundred and sixty-six patients had more than one of these conditions, and four had been prescribed diclofenac on repeat prescription.

In total 41 patients with any of the relevant diagnoses had been given diclofenac in

the preceding 12 months, of whom 19 had diclofenac on repeat prescription. Our results are somewhat reassuring as only 0.3% of our patient population have been exposed to diclofenac in the last 12 months with only 0.1% having diclofenac on repeat prescription. Although the service burden of these new recommendations is slight, the impact that the discontinuation of diclofenac will have on patients requiring them (particularly those that use diclofenac routinely) cannot be discounted.

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REFERENCE

1. Medicines and Healthcare Products Regulatory Agency. *Drug Safety Update. Vol 6, issue 11*. London: MHRA, 2013.

DOI: 10.3399/bjgp13X675377

Correction

In the August issue of the *BJGP*, the letter Gibney DR. Should we charge for A&E? *Br J Gen Pract* 2013. DOI: 10.3399/bjgp13X670543 included address details that should have instead been presented as: 4th Year Medical Student, Manchester Medical School. E-mail: daniel.gibney@student.manchester.ac.uk. The online version has been corrected.

DOI: 10.3399/bjgp13X675638