Letters

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Diagnostic safety-netting

Congratulations on your article that is very helpful for developing countries.¹ As you have mentioned, undifferentiated presentations and uncertainty in management are an important issue to GPs. I wish to include three clear situations:

- You may see the obvious 'redflag' that you will not miss or take a chance with. A middle-age female who presents with sudden onset, severe headache that she has not experienced before and no physical signs detected. This may be a subarachnoid hemorrhage even though you cannot exclude a first attack of migraine. Do not take any chances, play it safe.
- May expect a 'redflag' later. The article¹ mentioned that in some situations the time period is certain; for example, head injury leading to subdural hematoma. I do not agree as the safety-netting period may depend on so many factors. Site of injury, severity of injury, and age. Another classic example: a patient with heartburn has a normal ECG suggestive of gastroesophageal reflux disease. As you are aware 50% of ECGs in the first 6 hours could be normal. You may repeat after 6 hours and may rule out an infarct. I have seen a frank MI showing in the ECG even after 24–48 hours.
- A patient who has typical features suggestive of IBS has a diagnosis card indicating the same. The same patient is diagnosed with colonic carcinoma after 6 months. Have you misdiagnosed or have they developed a colonic carcinoma later?

These are questions we have to answer in general practice.

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DOI: 10.3399/bjgp10X483986

Looking at the patient

I wish to comment on the editorial in the February 2010 issue of the Journal.¹ My personal experience of analysing my consultations by video made it clear to me that the computer served as a very real barrier to effective non-verbal communication with patients. I noted that the position of the computer on my desk was of considerable importance. As the authors describe, the position of the lower body identified by Ruusuvaori² is crucial and as such, I found that angling the computer keyboard and monitor toward the patient without blocking my direct view, seemed to integrate the computer into the interaction with the patient much more effectively. This is a very simple reorganisation but interestingly I noted that in all of the eleven consulting rooms in our building, we were operating with a keyboard and screen placed at angle of 45–90 degrees away from the patient.

I agree entirely with the need to give full attention to the patient's opening statements before using the computer and also in signposting any referral to the screen. However, I have also been increasingly aware of the challenge of recording a full computerised record within the time constraints of a 10-minute consultation. I have been experimenting with entering data on the computer without breaking eye contact with the patient. This

requires typing skills, however, I have managed to pick these up having previously used the ubiquitous two-to-four finger typing technique over a relatively short period of 6 months or so and now consider it to have been a useful investment of time. This technique needs structuring with some explanation to the patient and seems to be best carried out during free flowing conversation in the consultation. However, it allows data to be entered unobtrusively and contemporaneously while still being able to engage in the offer and receipt of non-verbal information.

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DOI: 10.3399/bjgp10X483995

Persistent frequent attenders

We read with great interest the article by Luciano *et al* about frequent attendance in the BJGP.¹

The authors state that 'neither definition (has taken) into account that certain patients need to make more consultations than others,' and therefore, they study a two-stage approach in that they define frequent attenders according to four clinical profiles and to the top 25 and 10% top attenders.

Obviously sick patients will make more appointments with their GP and frequent attendance is linked to (multi-)morbidity. Therefore, we think that, from a clinical