

## Letters

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### What benefit testicular self-examination?

It was gratifying to read a paper on testicular cancer which acknowledged that there is no evidence that routine testicular self-examination (RTSE) is beneficial.<sup>1</sup> Indeed, there are strong theoretical arguments, which the paper alluded to, as to why RTSE is of no benefit and might even be harmful.<sup>2</sup>

The conclusion that, 'this study suggests that it is important that men are aware of the normal shape and feel of their testicles' is, however, not only a statement of the obvious, it is also open to misinterpretation by those well-meaning but misguided bodies who advocate RTSE.

The fundamental question is whether men need to self-examine — routinely or otherwise — in the absence of symptoms, to achieve this 'awareness'. The implication from the paper is that they should, and this is likely to be seized upon by men's health groups as vindicating their campaigns to encourage RTSE. But there is nothing in the paper to support this. Certainly, men categorised as 'seeking help relatively quickly' successfully detected a lump, but it is not clear how relevant prior awareness of normality was or how this was achieved — many realised that there was a problem simply because of comparison with the other testicle (for the vast majority of men, an obvious and readily available — but rarely mentioned — comparator).

Besides, those men categorised as delaying consultation seemed equally adept at detecting an abnormality; their problem was that they failed to act on it, a finding echoed in previous research.<sup>3,4</sup>

Supporters of RTSE or testicular awareness argue that, regardless of the lack of actual or theoretical evi-

dence, it might do some good and can't possibly do any harm. They will use this paper and its conclusions to support their arguments, ignoring the rather obvious fact that this research looked only at men who were confirmed as having testicular cancer. A similar study, assessing the anxiety and iatrogenesis suffered by the much larger group of men who via self-examination incorrectly thought they had cancer — and the resulting clogging up of ultrasound and urology services — might temper their enthusiasm.<sup>4</sup>

The priority given in Chapple *et al's* paper to encouraging awareness of testicular 'shape and feel' represents a distortion of their findings and a missed opportunity to inject some sense into this debate. The message we should be getting across is that the real issue is not men failing to detect testicular cancer but them failing to act on it.

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### Authors' response

Thank you for inviting us to respond to comments made by Hopcroft *et al*. We agree that obsessive self-examination might do more harm than good, but think that there is real confusion among professionals and the public about the difference between self-examination and 'being aware of changes'. This confusion also applies to the guidance about breast self-examination, another area where a readily available comparator is available (although our own experiences suggest that symmetry should not be relied upon in either sex).

Hopcroft *et al* argue that the real problem is that men do not 'act' when they suspect that something is wrong. Our paper explored the complex reasons why some men do not act when they suspect they have a problem. We concluded that men should certainly be made aware that testicular cancer is almost always curable and that treatment does not usually lead to long-term sexual problems. However, the clear recommendation of the men that we interviewed was that others should 'get to know your own body' (see 'Talking about discovery: signs and symptoms' and 'Talking about living with it: messages to others' on <http://www.dipex.org>), since it is only by knowing what is normal that any changes can be noticed and suspicious signs or symptoms acted upon.

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## Somatisation or not?

Rosendal *et al* and Love and Fahey tackled the difficult topic of somatisation and raised fundamental questions about how we view symptoms.<sup>1,2</sup> However, both pieces urge us to define an 'improved diagnosis' of somatisation that, I would argue, is neither possible nor helpful. To dichotomise symptoms into 'somatised' or, by implication, 'real', is as artificial as separating physical from psychological experience. Furthermore, it is unhelpful in that it reinforces stigma against psychological illness and exacerbates difficulties in engaging patients in psychological treatments.

A small number of patients attend repeatedly with psychological distress presented as physical symptoms, for whom a management plan acknowledging this is appropriate. However, most patients will have both physical and psychological elements to their presentation. Rosendal *et al* use a definition of somatisation as, 'a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness and to seek medical help for them.' Thus somatising can be seen as a process: initially experiencing a symptom, then interpreting it as illness, followed by consulting a health professional, who then uncovers no pathology. It is difficult to see which step in this process could be 'diagnosed' as abnormal. The 'diagnosis' of somatisation then rests on the doctor's decision as to whether to apply a pathological label to symptoms or not.

Love and Fahey highlight that diagnosis is irrelevant to many encounters in primary care and that the first priority is to exclude serious disease. The next priority should be to maintain a 'dual focus',<sup>3</sup> listening actively to the patient and seeking evidence for, and responding to, both physical illness and emotional distress. To assign a diagnosis of somatisation addresses neither of these priorities. Furthermore,

it provides a false reassurance that a diagnosis has been arrived at, when the definition above shows all that has been arrived at is a decision that nothing has been found yet.

By splitting symptoms into either 'somatised' or 'real' (or 'medically unexplained' versus 'medically explained') we perpetuate an artificial and harmful division between mind and body, which I believe general practice is ideally placed to reject.

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## Authors' response

Thank you for giving us the opportunity to discuss the relevance of applying the diagnosis 'somatisation' in general practice.

We agree with the author of the letter that a dichotomy between psychological and physical disorders is undesirable. We defined somatisation as stated above, but in our approach we regarded somatisation as the phenomenon that many physical complaints simply do not match the clinical picture of conventionally defined diseases. In accordance with this broadly defined concept we often use the terms medically unexplained symptoms or functional somatic symptoms (FSS). We have no wish to stigmatise this large group of patients and do not divide symptoms into somatised or real. On the contrary, we teach GPs to pay simultaneous attention to biological, psychological, and social factors in relation to

all patients presenting with physical symptoms and to acknowledge the reality of the patients' symptoms.<sup>1</sup> Our evaluations show that patients and doctors appreciate this approach.

Concerning the relevance of applying a diagnosis of somatisation, the issue may be viewed from a clinical and a research perspective. A diagnosis is a construct that makes it possible to conduct rigorous research and to make appropriate management decisions and predict prognosis. At present, most of our diagnoses in primary care focus on biomedical disease and physical symptoms, and patients with FSS are not given the same professional care as patients with physical diseases. Patients with persistent somatisation feel rejected by their GPs when the exclusion of physical disease is all that is offered,<sup>2</sup> and they may also risk a costly series of unnecessary investigations. Having a clinical diagnosis of somatisation or FSS could lead GPs to pursue an approach to FSS with a dual focus, instead of the prevailing continuous search for serious physical diseases.<sup>1</sup> In other words, a diagnosis would serve to secure a systematic, qualified approach to the complex problems that many of our patients have when they present physical symptoms, and would also render patients with FSS visible in primary care.

Another issue is whether there is a need for a diagnosis and a gold standard in research in general practice. In this case, a precise diagnostic categorisation is a prerequisite for valid comparisons within and between different studies and for precise communication between researchers.

Overall, we would find it very helpful if we could find common ground for diagnosis of somatisation or FSS in general practice. Whether this is possible, we do not know, but we would like to encourage future research to explore this field.

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## Diagnosis of bacterial LRTI

Graffelman *et al's* diagnostic rule to predict a bacterial lower respiratory tract infection (LRTI) clinically was developed using the best available statistical and diagnostic techniques.<sup>1</sup> We congratulate them on their unique successes in making an etiologic diagnosis in such a high proportion of patients. Little is generally known of the predictive values of symptoms and signs in primary care settings, and data from hospitals may not have applicability because of differences in incidence and severity of disease.<sup>2</sup> We therefore welcome contributions such as theirs.

However, their diagnostic rule contained three somewhat unexpected predictors for a bacterial LRTI (headache, fever, painful lymph nodes) and two predictors for viral LRTI (diarrhoea and rhinitis). To us, some of these factors lacked face validity. Closer examination of the logistic regression analysis revealed that this prediction rule was, for the

most part, built on variables that were not statistically significantly associated with bacterial LRTI: *P*-values greater than 0.05 and confidence intervals greater than unity (not always visible because of rounding of numbers). It is questionable whether the two remaining variables are clinically important, given the wide confidence limits on the odds ratios. These results are not surprising from a statistical point of view because a *P*-value greater than 0.1 was chosen as a removal criterion in the backward selection procedure. This practice may lead to statistically non-significant predictors. Moreover, the small number of cases ( $n = 84$ ), and the large number of variables ( $>30$ ), increase the likelihood of finding clinical predictors purely by chance.

The authors correctly state that their new prediction rule should be validated before uptake in routine care. Despite this, they conclude that differentiating between bacterial and viral infection is now possible. We feel that this optimism is premature. The translation of study results to management decisions in everyday care is of major clinical importance and we should proceed with caution. Their claims that their tool will help clinicians differentiate viral from bacterial infection could be seen as support for the misguided notion that all bacterial LRTI infections require antibiotic treatment. The authors correctly remind us that antibiotics should not be prescribed for viral LRTI. Unfortunately, they omitted to mention that the majority of patients with LRTI (including those who can be shown to be infected with a bacterium) are about as likely to benefit as to be harmed by treatment with antibiotics, and therefore the importance of etiological diagnosis at the bed- or chair side is over estimated.<sup>3</sup>

The most important question is rather which sub-group of patients, irrespective of initial infecting agent, will benefit from antibiotic treatment. To answer this, any validation study should prioritise prognostic (future) over diagnostic (immediate) outcomes.

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## Author's response

Indeed, exchange of ideas about lower respiratory tract infections (LRTI) is very valuable and we wish to thank the authors who responded to our paper for their contributions.

In response to the letter from Hopstaken *et al* we would like to make the following remarks. Of the predictors in our diagnostic rule, the presence of painful lymph nodes was surprising. We agree that when testing a large number of variables it is possible to find predictors by chance. In our group of patients with abnormality on chest auscultation, we found that headache, fever and painful lymph nodes were predictors for bacterial LRTI, and diarrhoea and rhinitis for viral LRTI. We are conscious of the statistical difficulties that were met. Our calculations were based on 84 patients (35 with bacterial LRTI and 49 with viral LRTI), a relatively small number of patients. To reduce the risk of excluding possible independent variables (Type II error) we used a *P*-value  $>0.10$  as removal criterion. The consequences could have been that we introduced Type I error and our conclusions could have been slightly

too optimistic. Thus, we recommended the need to validate our prediction rule in another population. Of course the choice of 0.10 or 0.05 as removal criterion can be debated. However, some of the variables (diarrhoea, headache, and fever) that we entered into the diagnostic rule just exceeded the 0.05 point. We agree that the translation of study results into every day practice should be done with caution. Although the general practitioners had free choice of management in our study population, nearly all of the patients were considered to be seriously ill and were treated with antibiotics. To identify patients with bacterial infection, which is the best marker of a benefit from antimicrobial treatment, our prediction rule could be a step forward to a more realistic prescription of antibiotics.

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### A voluntary patient support service in general practice

Research shows that over three quarters of patients visiting general practitioners (GPs) admit to having at least one psychosocial problem, one third of whom suggest that this has had a significant impact on their current health.<sup>1</sup> These problems may emanate from the home, socially, or within the workplace, and can lead to individuals becoming chronically stressed.<sup>2</sup> Whereas the burden of these patients has diminished following the introduction of practice counsellors, the role of community-based services; for example, Leukaemia Care Society, Stroke and Carers Group, Cruse Bereavement Care, and Mind, should not be overlooked. However, it has been shown that these services, many of which are voluntary, remain relatively under-utilised by GPs.<sup>3</sup>

To address this issue, a South Yorkshire practice has formed a voluntary team to ensure that community-based resources are employed more

effectively. This team, entitled the Patient Support Service (PSS), acts as an advisory/referral agency for patients whose problems are perceived to stem from underlying psychosocial factors. It is felt that these patients benefit from a support network that helps them to explore their problems, advises them and, where necessary, refers them to appropriate community-based services. Consequently, a patient's psychosocial state may be prevented from deteriorating by attending to, and hopefully resolving, the root cause(s) of their problem(s).

Once referred to the PSS by a GP or practice nurse, patients receive a consultation of up to 30 minutes during which volunteers help them to appraise their circumstances. Based on this appraisal, patients are provided with information regarding a series of community-based agencies where they can gain further support (for example, voluntary groups, social services or solicitors) and initial appointments will be arranged with the patient's permission.

The PSS, which is described in a study by Faulkner, has been shown to be an important adjunct to traditional approaches of referral in general practice, acting as a linchpin between the professional world of health care and the voluntary world of psychosocial support.<sup>4</sup>

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### Correction

In the January 2004 issue, in Graffelman AW, Knuistingh Neven A, le Cessie S, *et al.* A diagnostic rule for the aetiology of lower respiratory tract infections as guidance for antimicrobial treatment (*Br J Gen Pract* 2004; **54**: 20-24), there is a correction to Figure 1 on page 22. The legend for this graph (extended, clinical, and simplified score) was incorrectly labelled and the correct legend is shown below.

An amended version of this paper is available on the journal website: <http://www.rcgp.org.uk/journal/index.asp>

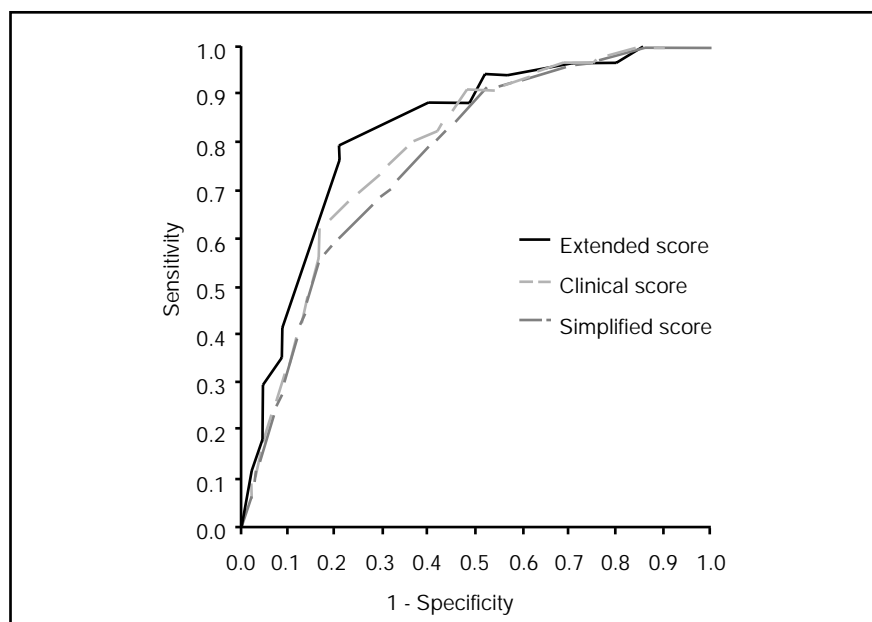


Figure 1. ROC curves of the extended, clinical and simplified score.