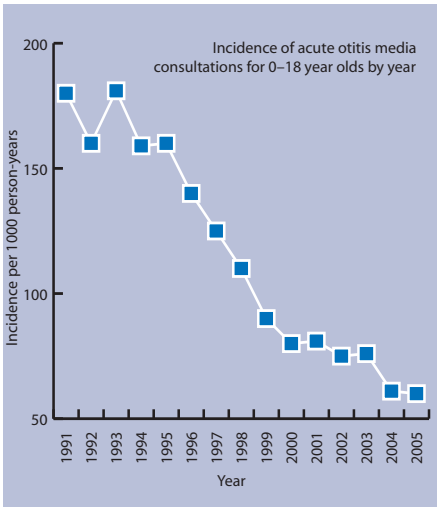

government initiatives to reduce unnecessary antibiotic prescribing,[2,3] and to decrease the number of consultations by encouraging the self-treatment of minor ailments[4] has now reached its peak effect, and is no longer influencing patient behaviour. Thus, continued surveillance of this trend is warranted to establish whether this is a long-lasting effect in patient behavioural change.

Paula L Thompson
Macey L Murray
Mike Sharland
Ian CK Wong

Centre for Paediatric Pharmacy Research, University of London, 29–39 Brunswick Square, London, WC1N 1AX
E-mail: paula.thompson@pharmacy.ac.uk

Competing interests
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Polycystic ovary syndrome

One of the laser treatments offered under the NHS in our region is facial hair removal in patients who are diagnosed with hormonal disorders such as polycystic ovary syndrome (PCOS).

PCOS affects 5–10% of women and symptoms may include infrequent or absent menses, infertility, weight gain, excessive hair growth and acne. Obtaining a diagnosis of PCOS can be a difficult and lengthy process. In this centre alone we have seen several patients in whom PCOS was suspected clinically, but not diagnosed, thereby precluding these patients from treatment with NHS funding. In one instance, a patient was forced to seek private consultation from a specialist who was able to confirm the diagnosis of PCOS. Uncertainties in the diagnosis arise largely from the wide diagnostic criteria described by a consensus in 2003 of the European and American societies for Human Reproduction and Embryology.[1] These guidelines state that PCOS can be diagnosed when two out of three criteria are satisfied; these being, evidence of infrequent or absent ovulation, ultrasonic evidence of polycystic ovaries (>12 cysts of 2–9 mm diameter), and biochemical or clinical evidence of hyperandrogenism. We suspect that patients who are eligible for NHS treatment of the symptoms of PCOS may be being denied laser or other treatment if they fail to meet just one of the diagnostic criteria. Where this is the case and there is clinical suspicion of PCOS, benefit may be gained from referral to a specialist team with a particular interest in PCOS. According to the criteria, a diagnosis of PCOS is still a possibility even in the face of normal biochemical and radiological tests that may have already been carried out by the GP.

DC Widdowson
PA Wright

Wessex Specialist Laser Centre
Department of Plastic and Reconstructive Surgery, Salisbury District Hospital
Wiltshire SP2 8BJ
E-mail: danielwiddowson@hotmail.com

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Genetic epidemiology and primary care

As a retired dinosaur and occasional locum, I read with great interest Blair Smith's paper.[1] I would certainly welcome improvement of my own genetic literacy, but I fear that with the present trend towards larger and more specialised general practice the doctor–patient relationships in primary care are being eroded at an alarming rate. The average patient repeatedly complains that 'I never seem to see my own doctor' and this situation will only deteriorate further with the ideas of dual registration and encroachment from the private sector. As he says, this is all very much in the future at the present time, so perhaps there will still be time to reverse some of the present trends and possibly even have the national database as a functional entity, but not, I think until a long time after I have dropped off my branch.

Michael H Draisey
Trenchards, Piddinghoe, East Sussex, BN9 9AT
E-mail: MikFME@aol.com

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