

other clinics. Of those right-sided lesions in our clinics the majority either have an associated IDA or a palpable abdominal mass, which means that any patients who present to our clinic with symptoms, but no IDA or an abdominal mass with a normal flexible sigmoidoscopy to 60 cms only very small numbers of patients have cancer. But this was not the subject for discussion in this paper. This is a stage after GP referral, and was not addressed by the data in this paper, but it does explain why our experience over the last 15 years in Portsmouth that flexible sigmoidoscopy alone in patients without an IDA or an abdominal mass is a powerful way of identifying most of the cancers which attend our clinic.

10. The method of recruitment to the trial was not on the basis as is stated, but was offered to all patients presenting with rectal bleeding. The group was divided up into those that accepted a flexible sigmoidoscopy, those that simply filled out a questionnaire and the third group that refused both. It was interesting that 40% of patients refused a flexible sigmoidoscopy.

11. Patients refusing referral to hospital and examination were indeed followed up after a reasonable time to check that they came to no harm.

12. It is interesting that our conclusions fall completely in line with the National Institute of Clinical Excellence Guidelines for referral of patients suspected of cancer recently published in the UK.

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Quite an eyefull

Unilateral conjunctival and lid infections are often treated in general practice. They are more likely to be related to trauma or foreign body irritation and it has always been debatable as to how long these infections should be treated in primary care before referral to a hospital ophthalmic clinic.

A 53-year-old bank service manager presented with a chronically irritable left eye, intermittent discharge, slight swelling of the eyelid and mild erythema. There was no loss of vision. His symptoms were managed in primary care for 1 year by his GP, optometrist and a local primary care eye clinic. There was poor response to a

variety of antibiotics and bacterial swabs, including testing for chlamydia, were negative. As a result, he was referred to the regional ophthalmology department.

Examination at the ophthalmology department of the affected eye revealed mild blepharitis of upper and lower lids, mild erythema and moderate swelling and induration of the left upper eyelid. Eversion of the left upper eyelid revealed a deeply embedded contact lens in the tarsal plate with conjunctivalisation of the lens and a surrounding area of inflammatory granulomatous tissue. At the slit lamp, the contact lens was removed leaving an indentation in the tarsus of similar shape and size to the lens. The contact lens was sent to microbiology, which did not grow any organisms including testing for *acanthamoeba*.

Further questioning revealed that the patient had lost a gas permeable contact lens 14 years ago. Since 1980, there have been published cases reporting retained contact lenses in the eye for several years. Hard gas permeable contact lenses seem to be the main culprits in all of these cases, usually migrating and settling in the upper eyelid. Patients were more likely to present with inflammation or a mass in the eyelids rather than infection.

We wish to highlight the need to perform eversion of the upper eyelid in cases of prolonged and non responsive ophthalmic infection and inflammation. This is also essential where there is unilaterality of signs and negative laboratory tests. While this remains an unusual scenario it serves to remind clinicians not to overlook this simple and necessary step towards complete ophthalmic examination.

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Euthanasia

Pasterfield *et al*, looking at GPs' views on changing the law on physician-assisted suicide and euthanasia, end with a question.¹ Why are most GPs opposed to changing the law whereas patients largely are seen to support such a measure? To this I would add a further question. Why are a larger percentage of palliative care doctors

opposed to such a change than GPs?^{2,3} If one sees these two questions as being linked, an obvious hypothesis emerges. The hypothesis is that increasing experience of good palliative care is associated with the belief that legally allowing euthanasia is unnecessary and potentially dangerous.

Many of us will remember cases of appalling palliative care while in our house officer years. Hearing comments of families in the lead up to the Joffe Bill debate illustrates that many such bad stories are also in the public domain. As a GP, the benefits of good palliative care to my patients and their families rapidly became apparent. These good stories, however, are not media big sellers. As a result, a balanced view on end of life care is only available to a privileged few. We as GPs are able to experience this to a degree, often depending on how well resourced our local palliative care services are. Palliative care clinicians, on the other hand, live these stories with their patients on a daily basis.

As doctors we have a unique insight into the dangers of legalising euthanasia. Many of us will have been in a position where we have been directly or indirectly asked to end a patient's life. However, once the reason behind the request has been identified and addressed, the request is usually withdrawn. Palliative care clinicians, who meet these requests more frequently, tell me that their most common experience is the same. As GPs and palliative care clinicians we see errors in prognosis and diagnosis. We see the use of time as a therapeutic tool: patients who once wished themselves dead, are glad to be alive. We see how tired families can become caring for a loved relative, so that death can seem like a welcome release, not so much for the patient, but for the family.

Does exposure to good palliative care result in opposition to legalised euthanasia? Is it worth further research? I think so.

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