Letters

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MRSA carriage

Mulqueen *et al*[1] describe the prevalence of MRSA carriage among GPs in the West of Ireland and note accurately the lack of data available on prevalence rates of MRSA in the community. Having made the same observation, I conducted a study within a general practice community in rural northwest Ireland last year. All consecutive attendees at the surgery over a 2-week period in December 2006 were invited to participate until a sample of 114 was obtained. Data on previously identified risk factors for MRSA carriage, such as recent hospital admission, antibiotic use in the last 3–6 months,[2] and having a chronic disease,[2–4] was collected on participants and a single nasal swab was taken from the anterior nares. Only one case of MRSA carriage was identified giving a point prevalence of 0.9% (95% CI = 0.25% to 5.57%). That subject had none of the categorised risk factors. We did not test the GPs serving this area, but the setting of our study is very similar to your published study in which the nasal carriage rate among GPs was 7%.[1] In the literature there were three similar population studies to be found from the UK — all of which report a comparable prevalence figure. (0.8–1.5%)[3,5,6] If these two Irish studies tell us anything it is that we are more likely to convey MRSA to our patients than the other way around, whether this is from our high rate of carriage or our high rate of prescribing, we would do well to be constantly aware of our primary ethical principle and first do no harm.

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REFERENCES

1. Mulqueen J, Cafferty F, Cormican M, *et al.* Nasal carriage of meticillin-resistant *Staphylococcus aureus* in GPs in the West of Ireland. *Br J Gen Pract* 2007; **57(543):** 811–813.
2 Hidron AI, Kourbatova EV, Halvosa JS, *et al.* Risk factors for colonization with methicillin-resistant *Staphylococcus aureus* (MRSA) in patients admitted to an urban hospital: emergence of community-associated MRSA nasal carriage. *Clin Infect Dis* 2005; **41(2):** 159–166.
3. Grundmann H, Tami A, Hori S, *et al.* Nottingham *Staphylococcus aureus* population study: prevalence of MRSA among elderly people in the community. *BMJ* 2002; **324(7350):** 1365–1366.
4. Jernigan JA, Pullen AL, Partin C, Jarvis WR. Prevalence of and risk factors for colonization with methicillin-resistant *Staphylococcus aureus* in an outpatient clinic population. *Infect Control Hosp Epidemiol* 2003; **24(6):** 445–450.
5. Maudsley J, Stone SP, Kibbler CC, *et al.* The community prevalence of methicillin-resistant *Staphylococcus aureus* (MRSA) in older people living in their own homes: implications for treatment, screening and surveillance in the UK. *J Hosp Infect* 2004; **57(3):** 258–262.
6. Abudu L, Blair I, Fraise A, Cheng KK. Methicillin-resistant *Staphylococcus aureus* (MRSA): a community-based prevalence survey. *Epidemiol Infect* 2001; **126(3):** 351–356.

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Gaelic

I write in response to your appeal in December's Journal for any readers who might be familiar with the language of the Garden of Eden to supply a translation for the concluding solicitudes in Neville Goodman's last column.[1]

The first two are quite staightforward, meaning 'blessings with you' and 'thank you' respectively. The first is commonly used to bid farewell. The third one is slightly more complicated and literally translated means 'good providence to you'.

To appreciate those statements you need an awareness of the culture as well as the language that inspired them. As luck is not a Hebridean concept at all there is no word in Gaelic for it. Most people in the Western Isles still believe that there is a certain order to life, and death, and who in our profession could argue with that. So in wishing people well for the future as you part company we cannot say 'good luck' but rather express the wish that providence might be good to them.

Neither of course do we believe very much in Christmas as it is celebrated nowadays, as it has more to do with the birth of Santa Claus some 100 years ago than with a certain event in Bethlehem some 2000 years ago.

So I will refrain from wishing you and your readers a Merry Christmas as it will be well past by the time this is published anyway. I will however wish all those who read your Journal and especially my colleagues on the Panel of Examiners a prosperous and happy New Year as they undertake the transition from old to nMRCGP. So far providence has been on their side. Lets hope it remains so.

Leis gach durachd (With every good wish).

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REFERENCE

1. Goodman N. A long, strange trip. *Br J Gen Pract* 2007; **57(545):** 1003.

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Sexual enquiry in older people

Sexual wellbeing is likely to be an important aspect in the management of older mental health patients as increasing age[1] and mental illness[2] can both adversely affect sexual practice and satisfaction. With this in mind, we explored the expectations and attitudes of people over age 65 years with mental illness towards sexual healthcare with an anonymous, cross-sectional postal survey. Participants (mean age 78 years) were patients affiliated with old-age psychiatric services at St Charles Hospital, with 64% having diagnoses of either dementia or depression. A total of 139 surveys were posted, 30 were returned (22% response rate) and six people complained.

We found that most responders (18,

82%) believed doctors should enquire about sexual matters, although only the minority (2, 9%) had been involved in such discussion with their doctor. Many responders (14, 64%) felt at ease with sexual discussion, yet, few (5, 23%) regarded their doctor as comfortable with this. Furthermore, women reported less comfort, but no less interest in sexual discourse than men (P = 0.03), suggesting particular understanding should be employed when taking sexual histories from older females. Increasing age (P = 0.03) and cohabitation (P = 0.08), were found to be associated with a decreased desire to discuss sexual issues.

Aged sexuality is still a taboo. It is widely believed by doctors that sexual enquiry is inappropriate and often unnecessary among older adults,[3] however, this study and American research[4] indicate that this is not always the case. The implication being that physicians are not meeting the sexual healthcare needs of older mental health patients.

While we found reluctance among many older people to respond to the survey, of those who did, most older patients wished to be asked about sexual issues. However, clinicians need to do this sensitively. The lack of response, and number of complaints about the survey, highlights a crucial finding; while sexual enquiry is acceptable and welcomed in the US, it may not be so well tolerated in the UK.

In summary, many older age psychiatric patients want to talk about their sex lives with doctors but are currently not afforded the opportunity. GPs are well placed to assess issues of sexual dysfunction. Older, UK-based populations are difficult to survey regarding sex but this study indicates that further research would be valuable.

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REFERENCES

1. Masters W, Johnson V. Sex and the aging process. *J Am Geriatr Soc* 1981; **29(9):** 385–390.
2. Matthias R, Lubben J, Atchison K, Schweitzer S. Sexual activity and satisfaction among very old adults: results from a community dwelling population survey. *Gerontologist* 1997; **37(1):** 6–14.
3. Bouman W, Arcelus. Are psychiatrists guilty of 'ageism' when it comes to taking a sexual history? *Int J Geriatr Psychiatry* 2001; **16(1):** 27–31.
4. Bedell E, Duperval M, Goldberg R. Cardiologist's discussions about sexuality with patients with chronic coronary artery disease. *Am Heart J* 2002; **144(2):** 239–242.

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Top tips

Regarding 'Top Tips in 2 minutes', Ruth Bastable, *et al*,[1] mentions 'you are asked to talk for an hour'. She will find the audience asleep. They can concentrate for 35 minutes with a maximum of 25 slides. Then questions for however long the organiser requires. That's when the audience wakes up again. She must have a good chairman. Speakers who extend their time are a menace and should be stopped.

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REFERENCE

1. Bastable R, Rann S, Barker V. Top Tips in 2 minutes. *Br J Gen Pract* 2008; **58(546)**: 62.

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Doctors' content

The editorial[1] discussing the Original Paper of the same issue, by Whalley, Sibbald and Gravelle[2] states that there is 'contentment in general practice — for now'. While accurately reflecting the contents of the paper you fail to highlight that the latest survey was over 2 years ago. I would humbly suggest that a survey reported now would give markedly different and more negative responses. Management at the Department of Health and in PCTs though will no doubt find succour in your editorial.

I am concerned that the *British Journal of General Practice* should not have reflected the fast moving changes in attitude that are currently present in general practice and in failing to do so will lose credibility with our colleagues.

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REFERENCES

1. O'Dowd T. Contentment in general practice — for now. *Br J Gen Pract* 2007; **50(546):** 5–6.
2. Whalley D, Gravelle H and Sibbald B. Effect of the new contract on GPs' working lives and perceptions of quality of care: a longitudinal study. *Br J Gen Pract* 2007; **50(546):** 8–14.

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Participating in media surveys

I listened with weary resignation to BBC radio and television on 31 Dec 2007 that ran a story on urgent and non-urgent GP referral of women with lumps to breast clinics.

The item was based on a small survey of 200 GPs for Radio 4 which was carried out by the charity Breakthrough Breast Cancer. The story was headlined as 'Cancer referral confusing GPs'.

The survey recognised that most family doctors were following NICE guidelines. This fact, however, was lost in the media clamour which picked up on one aspect of the survey which was that about a third of GPs stated they would use judgement on whether to refer urgently a woman under 30 with a lump. This was seized on as a breech of guidelines and of course it grabbed all the (negative) headlines.

Making referral decisions using guidelines and clinical judgement, instead of simply following guidelines at all times, seems to be regarded as negligent by the media and pressure groups. Do they really think that in this case, it would be better to refer all women with a breast lump under the 2-week rule and overload the system?

The open season on GPs continues.

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