Re: Advertisements

As we have pointed out previously, we accept advertisements that are compatible with the RCGP's Advertising Guidelines, and expect readers to exercise their own critical faculties, as Dr Ashworth has done here — Ed.

DOI: 10.3399/bjgp08X279887

Appraisals

Conlon concludes in his editorial on regulation[1] that GPs need to make a personal choice between independent and interdependent practice, but this seems a false dichotomy. Most GPs are both independent in the sense of practising unsupervised, and interdependent in that they work with, and are supported by, other professionals and GP colleagues, particularly in practice teams.

His vision of a supportive organisation, in which doctors welcome performance measurement and scrutiny as ways of understanding and improving their work, is attractive. Unfortunately, given the lack of understanding and appreciation of the roles and efforts of doctors shown by Government and the Department of Health over the last two decades, the NHS is unlikely to become such an organisation.

Besides, it is still questionable whether it is possible to develop measures of GP performance which are meaningful and useful enough to justify the costs, especially in doctor time, of their development and application. However good the measures, making them part of the appraisal in today's NHS would risk undermining appraisal's supportive and developmental role, and reducing the number of GPs who value it to even less than the disappointing 40% reported by Colthart, *et al*[2] in the same issue of the Journal.

John Temple
GP appraiser, 74 Park Road, Chilwell, Nottingham NG9 4DD.
E-mail: John.Temple@nottingham.ac.uk

REFERENCES

1. Conlon M. Regulation: appraisal alone is not enough. *Br J Gen Pract* 2008; **58(547):** 80–81.
2. Colthart I, Cameron N, McKinstry B, Blaney D. What do doctors really think about the relevance and impact of GP appraisal 3 years on? A survey of Scottish GPs. *Br J Gen Pract* 2008; **58(547):** 82–87.

DOI: 10.3399/bjgp08X279896

Management of headache

In response to Kernick, *et al's*[1] article I would like to describe my approach to primary headache. In the 1980s my husband, then a medical registrar, would regularly spend Mondays after weekends on call in bed with a prostrating symmetrical headache accompanied by vomiting. During my first pregnancy he came with me as a dutiful father-to-be to relaxation classes. The relaxation techniques we learnt and practised were invaluable to me in labour. The unexpected outcome was that my husband's headaches resolved. It is debatable whether they were tension headaches, or migraine without aura. According to Goadsby[2] classification is still controversial. However, many headaches in primary care fall in this uncertain category.

When patients present with tension headache I encourage them to think about muscular relaxation particularly of the muscles around the head, neck and shoulders. I explain that the scalp is covered by a layer of muscle like a swimming cap, which connects with the face, the jaw, the back of the neck and shoulders, and that tightness in these muscles may produce pain as in any clenched muscle. Often examination reveals tenderness at the temples or occiput or in the neck extensors, which illustrates the point. I encourage the patient to become aware of frowning, or raising the eyebrows, or clenching the jaw, and to focus on relaxing these muscles.

This explanation might be simplified or inaccurate as pathophysiology, but there are benefits of a clear diagnosis and explanation. First, if patients fear brain tumour, it is much more satisfactory to have a definite diagnosis than to be told 'nothing is wrong'. Second, some patients resent the label of tension headache for its psychological implications. Often, patients with tension headache do have anxiety or depression which may be rewarding to explore, but others say, 'I'm not tense!' Here it is helpful to discuss muscular relaxation.

I note in *BMJ Clinical Evidence* on tension headache[3] that relaxation is mentioned, but is described as time-consuming to apply. I would dispute this. I think the principle can be explained quite quickly, and patients can be referred to self-help materials and relaxation tapes. Some women remember being taught relaxation at antenatal classes.

I also encourage patients to look for precipitants and trigger factors. The pathophysiology of these, and whether they apply to migraine without aura or tension headaches is again not clear to me, but pragmatically the following list is worth considering, and patients often notice something they had not previously thought of:

- caffeine, chocolate, cheese, citrus fruits and juices, onion, raw apple, alcohol; also
- fatigue, lack of fluid intake, or missed meals.

I note that Goadsby[2] says, 'so much good can be done for migraine sufferers and so little for tension-type headache'. This impression may well be behind GPs' difficulties. I suspect the lack of research into tension headache reflects the lack of pharmaceutical prospects. I would be interested to know how other GPs approach this problem.

Alison Jackson
GP, Green Lane Medical Centre, Coventry.
E-mail: alison.jackson@nhs.net

REFERENCES

1. Kernick D, Stapley S, Hamilton W. GPs' classification of headache: is primary headache underdiagnosed? *Br J Gen Pract* 2008; **58(547):** 102–104.
2. Goadsby PJ. Headache. In: Warrell D, Cox TM, Firth JD, Benz EJ (eds). *Oxford textbook of medicine.* Oxford: University Press, 2004.

http://www.doctors.net.uk/onlinebooks/main.aspx?book=62 (accessed 13 Mar 2008).
3. Silver N. Headache (Chronic tension-type). In: BMJ Clinical Evidence. http://clinicalevidence.bmj.com/ceweb/conditions/nud/1205/1205.jsp (accessed 13 Mar 2008).

DOI: 10.3399/bjgp08X279904

Headache management in general practice

Reading David PB Watson[1] and David Kernick,[2] we are really impressed by the strong similarities between the UK and Italian situation in this field.

As a neurologist working in a headache centre (out-patients service) in Milan, and a GP with teaching roles, we agree of course with all the theoretical statements by Watson (90% primary headache, no need for imaging in most cases, etcetera), and also with the complaint about limited GPs' interest and participation in headache patients' care and follow-up.

We have just one remark to add: for a correct diagnosis, a careful history is very important, but what is also useful is a neurological examination (and maybe a fundus of the eye examination). Both could be performed by a skilled GP, and only in some cases may require a specialist consultation.

Also for follow-up, GPs, being closer to their patients than specialists, could obtain easier careful registration for the course of headache attacks, and could prevent medication abuse.

Marina Mesina
Department of Neurology — Headache Centre, St. Charles Hospital, Milan.
E-mail: marina.mesina@sancarlo.mi.it

Francesco Carelli
Professor GP, University of Milan.

REFERENCES

1. Watson D. Easing the pain: challenges and opportunities in headache management. *Br J Gen Pract* 2008; **58(547):** 77–78.
2. Kernick D, Stapley S, Hamilton W. GPs' classification of headache. *Br J Gen Pract* 2008; **58(547):** 102–104.

DOI: 10.3399/bjgp08X279913

Sexual problems in later life

James Warner and colleagues are right to argue that older people are less reticent in discussing their sexual activity and problems than doctors believe.[1] In a randomised controlled trial of health promotion with patients aged 65 years and over recruited through general practice, we asked 1090 responders the question: 'How often have you experienced sexual problems in the last month?' The choice of answers was 'never', 'seldom or sometimes' and 'often or always'. One thousand and-fifty-three (93.6%) answered the question, of whom 72 (6.8%) answered 'seldom or sometimes' and another 72 (6.8%) answered 'often or always'. Among men, 121 (25%) reported that they had a sexual problem, while only 23 (4%) women did so. Sexual problems were reported by 17% of those aged 65 to 74 years, 21.5% of those aged 75 to 84 years, but only 4% of those aged 85 years and over. We do not know what the sexual problems were, and can only speculate that the predominance of men suggests that prostatic hypertrophy, medication adverse effects, or diabetic neuropathies were major causes. Further investigation is needed here. We do know that there was no association between having sexual problems and self-rated health; 33.5% of those rating their health as good to excellent also reported sexual problems, compared with 30% of those describing their health as fair or poor. Our sample was self-selected and relatively well (those with significant disabilities were excluded from the trial), so we may be under-estimating the prevalence of sexual problems in later life. The clinical implications for GPs are that sensitive discussion of sexual problems with men, up to the age of 85 years, is likely to reveal a significant burden of morbidity, but it is not clear whether it will be tractable. If our findings are typical, few older women will report sexual problems.

Steve Iliffe
Professor, Research Department of Primary Care, UCL, Royal Free Campus, Rowland Hill Street, London NW3 2PF.
E-mail: s.iliffe@pcps.ucl.ac.uk

Kalpa Kharicha
Senior Research Fellow, University College London

Daniel Harari
Consultant Geriatrician, Kings College London

Cameron Swift
Professor of Medicine for the Elderly, Kings College London

Andreas Stuck
Professor of Geriatric Medicine, University of Bern, Switzerland.

REFERENCES

1. Warner J, Starren E, Walker G. Sexual enquiry in older people. *Br J Gen Pract* 2008; **58(547):** 125–126.
2. Stuck AE, Kharicha K, Dapp U, *et al*. The ProAge study: an international randomised controlled study of Health Risk Appraisal for older persons based in general practice. *BMC Med Res Methodol* 2007; **7:** 2.

DOI: 10.3399/bjgp08X279940

Antibiotic-associated diarrhoea

Our vocational training group discussed the paper of Conway, *et al* with great interest.[1]

Antibiotics change the microbial balance in the gastro-intestinal tract and can cause antibiotic associated diarrhoea (AAD). Antibiotics are frequently prescribed in general practice and AAD is common among this population. The rates of AAD vary from 3% (penicilline G and V) to 23% (amoxicillin clavulanate) depending upon the specific type of antibiotic. A study in children showed that this variation is statistically significant.[2] AAD might be caused by the disruption of the normal flora and overgrowth of pathogens.[3] Probiotics have been suggested to prevent AAD by restoration of the gut microflora.

In the study of Conway *et al*, all patients who were prescribed a 1-week course of