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Headache management in general practice

Reading David PB Watson¹ 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.

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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.

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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