Letters

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Bell's palsy and Lyme disease

I read with interest Richard Davenport *et al*'s useful and informative editorial on Bell's palsy in the August *BJGP*.[1] It may be useful for GPs to be aware of some differences in the aetiology and therefore management of children with Bell's palsy for us on the south coast. As many will be aware, the New Forest in Hampshire near Southampton has traditionally been a hot spot for Lyme disease. Lyme disease can present in many ways; neuroborreliosis is the most common secondary manifestation of Lyme, and Bell's palsy the commonest presentation of neuroborreliosis. It is clear, however, that the tick which causes Lyme's is now more widespread and over the last 2 years in Winchester, north of the New Forest, we have seen cases of Lyme meningoencephalitis, arthritis, and multiple cases of Bell's palsy. A significant proportion of Bell's palsy have positive Lyme's serology; so much so that some of our consultants are considering Amoxil® or doxycycline (in the over 12's) as early 'blind' treatment options as well as the more traditional prednisolone with or without aciclovir as described in the editorial. Of note is the fact that very few of the group of Lyme serology positive Bell's palsy have had a history of a tick bite although many live in rural areas. Tick bites in children are often in the hair, hence very difficult to find and correctly identify.

I thought this information might be of use to GPs in the south, and perhaps with global warming may be more useful further afield!

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Early experience

Ten months ago our practice commenced an 'extended hours' service intended to serve patients unable to attend the surgery during working hours.[1] Some colleagues chose to work an evening surgery while I elected to start early. I can remember back in October 2008 the first patient, an 80-year-old retired gentleman, arriving yawning and bleary eyed for a review of his regular medication. Upon asking how he was he replied, 'Terrible doctor, do I really need to come this early to see you? They said it was the only slot left!'.

Now almost 1 year into the extended hours we decided to review its usage. We looked back over the last 6 months of a once-weekly 07.40 Tuesday surgery start.

Between 1 March 2009 and 31 August 2009, 34 pre-8 a.m. appointments were booked. There were four DNAs, 14 appointments for new problems, and 16 for follow-up and ongoing patient management. The mean age of patients was 44 years with no patient older than 66 years and the youngest aged 16 years. Five patients had taken up early appointments on more than one occasion. The majority of appointments were for women, 24/30 (80%).

The ratio of women to men is in keeping with the rest of my morning surgery appointments for the same 6-month period 638/846 (75%). Although the numbers involved are small, DNAs for the early morning appointments was 12% (4/34), twice the rest of the morning surgery, 5.6% (50/896).

Although the DNA rate will need to be reviewed in the future, it certainly seems that early starts suit particular patients well, as is indicated by repeated booking of these slots by some of them. It is apparent that patients of a working age are those taking up these appointments and the reception staff must be thanked for their role in helping the adaptations to the new surgery times. As the dark winter mornings draw in, we will see if these trends continue.

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ENT 2–Week Wait audit

Interested in the effectiveness of the 2-Week Wait (2WW) referral system, we

undertook an audit while doing our ear, nose, and throat (ENT) ST2 rotations for our general practice specialist training.

We were surprised by some of our findings. Of the 177 patients referred using the GP 2WW pathway during a 7-month period, 100% were meeting targets to be seen within 2 weeks, but only 6% (13/177) of these referrals were consequently diagnosed with head and neck cancer. In comparison to the incidence of cancer audited to be 23%[1] for urology and 12.8%[2] for breast 2-week wait referrals, ENT referrals appeared to have a much lower pick-up rate. In addition, of the 94% of the 2WW referrals which proved not to be cancer, we identified a sizable proportion that did not comply with the NICE 2WW referral guidelines.

While it is unavoidable that there will be a percentage of suspected cases that will have malignancy excluded by secondary care investigations, a large number of these 2WW ENT referrals may be given unnecessary priority over other general referrals thought to be less urgent, but which still affect a patient's quality of life.

Previously, other audits have shown a similar discrepancy with ENT referrals, and there have been multiple proposed reasons to explain this. For example, lack of knowledge of the 2WW referral criteria, or conversely, the poor predictive value of many of the 2WW referral criteria as symptoms suggestive of cancer. In addition, there has been suggestion of the inappropriate use of the 2WW referral system by primary care services. But perhaps there are significant contributing factors underlying all of these explanations — lack of clinical ENT experience, knowledge, and available diagnostics.

There is certainly some diagnostic difficulty with ENT malignancies relative to other types of cancer presenting in primary care. ENT symptoms of malignancy can be relatively non-specific and there are a lack of diagnostic aids, such as tumour markers and radiological investigations, making a malignancy difficult to exclude without an early referral. This difficulty only highlights the importance of clinical acumen in ENT assessment and diagnosis in primary care.

Despite ENT conditions making up to 25–50% of all GP consultations,[3] with many chronic ENT problems managed solely in primary care, practical knowledge and experience in dealing with ENT problems by GPs may have scope for improvement.

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Mozart in my practice

In the August issue Dawn Brittain and Melvyn Jones investigated if music in the waiting room could be accepted by patients and staff.[1] Discussing their research, they found debatable results, with a majority of patients in favour of music (mainly classical). There was no significant effect on patients' anxiety and health status.

I would like to highlight the relaxing side of music and analyse the effects of different kinds of music, depending on what we would like (or need) to achieve.

In this context, I thought about the use of music in my many years in practice and I realised that Mozart's music, and more specifically the piano concertos, are the best in my experience.

I find that Mozart's music can reduce the stress and tension in a busy and hectic general practice. I presented this theme in Zurich during an EQuiP meeting in October 1997 and again at the WONCA Congress in Palma de Mallorca in 1999.

For years I have used this music as light company in my waiting room and reiterate that the piano concertos are the best as they are smooth, without rapid changes of rhythm and sound, and with greater continuity.

The effects on patients are always very welcome; creating a relaxed environment and breaking any tension.

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