also agree that recording sufficient data during the time constraints of the consultation is a significant challenge. We need to be aware that the average UK primary care consultation with booking intervals of 10 minutes is on the short side for comparable countries and it may be that we need to consider giving ourselves more time.

The problem with the suggestion of typing while we talk (or listen) is that, from a patient's perspective, a doctor who is typing at the same time as they are listening is likely to be perceived as not listening as effectively as a doctor who is simply listening — and in many cases this perception will be correct.

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REFERENCES

1. Hay GI. Looking at the patient. *Br J Gen Pract* 2010; **60**(573): 293.
2. Silverman J, Kinnersley P. Look at the patient before you look at the computer. *Br J Gen Pract* 2010; **60**(571): 76–78.

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Aches and pains in primary care

GPs can do very positive things for some patients with aches and pains as many such patients are Vitamin D deficient. Vitamin D deficiency commonly presents with widespread aches, weakness, and tiredness, and can also present with focal symptoms. If a patient has several musculoskeletal diagnoses over time (for example plantar fasciitis, hip pain, back pain, and knee pain) then Vitamin D deficiency should be suspected. Deficiency can be confirmed biochemically by checking Vitamin D

levels. Expert consensus suggests that optimal Vitamin D status requires serum levels of 25 OH Vitamin D of 75 nmol/l (that is, 30 µg/l) or more (repeat levels 3 months after initial treatment to ensure patients are replete). Recent work shows 'no credible evidence' for hypercalcaemia at treatment doses of Vitamin D.¹ Treatment must be with adequate doses (for example, 400 000 iu in the first 2 weeks and then 20 000 weekly) as low dose supplements containing calcium will not restore Vitamin D levels, nor give symptom relief. This condition is common in all ethnic groups, especially in the north and west of the country, and is often forgotten or missed.

I received this comment recently, after treatment (of a white middle-aged man). 'I feel 10 years younger with fewer aches and pains. Mood and energy levels are much improved. I can get about to go fishing much more easily'. Many patients have similar positive experiences.

Moreover, treatment may improve general health as it is now well recognised that Vitamin D deficiency is a risk factor for many other conditions including cardiovascular disease, diabetes, cancer, and infections.²

Finally, patients may approach exercise with more equanimity if the hopeful phrase 'wear and repair' is used instead of the sinister 'wear and tear'.

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REFERENCES

1. Quinton R, Gan EH, Wahid ST. Hypercalcaemia. Two myths. *BMJ* 2009; **339**: b5649.
2. Pearce SH, Cheetham TD. Diagnosis and management of Vitamin D deficiency. *BMJ* 2010; **340**: b5664.

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Stop and think or think and stop?

The editorial by Hall *et al*,¹ was a brief

but fairly comprehensive overview of an area relevant to all GPs. The assessment of whether to continue previously prescribed medication need not, of course, be confined to terminal cancer sufferers. Motor Neurone Disease, end-stage organ failure, and advanced dementia are other conditions that spring to mind. My own feeling is that in current practice we probably leave such decisions until they are not decisions at all but rather when swallowing becomes an issue or other problems/side effects occur.

My wry observation is that their own rhetorical question to the title could be misinterpreted. I assume the authors mean it might be time to 'think and stop' rather than the more reactionary converse!

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REFERENCE

1. Hall PS, Lord SR, El-Laboudi, *et al*. Non-cancer medications for patients with incurable cancer: time to stop and think? *Br J Gen Pract* 2010; **60**(573): 243–244.

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Is stroke a 'trigger'?

The link between stroke and vascular dementia is known;¹ reports of psychological disturbance as a direct consequence of brain insult is noted. For example de Groot *et al*,² found white matter lesions after depressive episodes in patients with yet more curious phenomena emerging during counselling.

After working at the Neurorehabilitation Unit, Brighton, it was noted that stroke patients contended with an unusual legacy of past traumas. Disclosed psychological problems originated many years previously: childhood sexual abuse or the re-living of events gave rise to classical post-traumatic stress disorder (PTSD). A

proportion are expected to present with psychological difficulties unrelated to their current condition.

Importantly, symptoms similar to PTSD have been seen in patients diagnosed with cancer.³ The shock of receiving a diagnosis can be as powerful as a natural disaster or a traumatic road traffic accident. Reports of PTSD in cancer survivors is recognised⁴ and around 20% are varying with type of cancer and the methodology of the study.⁵ Yet no work has been published describing whether it is the same or responds to the same treatment as PTSD following other traumas.

Possibly, PTSD symptoms after stroke may be delayed onset of past psychological traumas. Equally compelling is that

chemical/neuroanatomical changes 'trigger' previously unresolved traumatic symptoms as with white matter lesions signalling depressive episodes. Adjustment to loss of previous functional abilities or brain-chemical instability may explain some presentations.

The author and colleagues are considering the efficacy of psychological approaches to treating PTSD in cancer survivors in a randomised control trial this year. Further work will consider stroke patients and the need for staff awareness of this phenomenon.

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REFERENCES

1. Thompson SB. *Dementia and memory: a handbook for students and professionals*. Aldershot: Ashgate Publishing, 2006.
2. De Groot JC, de Leeuw FE, Oudkerk M, *et al*. Cerebral white matter lesions and depressive symptoms in elderly adults. *Arch Gen Psy* 2000; **57**(11): 1071–1076.
3. Geffen DB, Blaustein A, Amir MC, Cohen Y. Post-traumatic stress disorder and quality of life in survivors of Hodgkin's disease and Non-Hodgkin's Lymphoma in Israel. *Leuk Lymphoma* 2003; **44**(11): 1925–1929.
4. National Institute for Clinical Excellence. *Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care, guideline CG26*. London: NICE, 2005.
5. Mehnert A, Koch U. Prevalence of acute and post-traumatic stress disorder and co-morbid mental disorders in breast cancer patients during primary cancer care: a prospective study. *Psychooncology* 2007; **16**(3): 181–188.

DOI: 10.3399/bjgp10X501949