primary care, none had a possible diagnosis of melanoma on the request form, delaying pathological diagnosis, impeding clinico-pathological correlation, and correct diagnosis. Dermatologists expected melanoma in 54/60 and plastic surgeons in 29/43.

Modern dermatological diagnosis of melanoma assisted by dermoscopy has a high sensitivity of 0.88 and specificity of 0.86.[4] In Murchie *et al*s' study the correct diagnosis was only given in 19.5% of melanomas diagnosed in primary care.

If services are provided by practitioners who are poor on diagnosis, irrespective of surgical competence, then unnecessary excisions will waste resources, and the risk of melanoma being missed is increased. The authors' assertion that if excision is complete then 'differences in diagnostic skill do not matter' is at least shortsighted or intended to provoke controversy.

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Primary excision of cutaneous melanoma

I read Murchie *et al*'s article[1] concerning primary excision of cutaneous melanoma by GPs and secondary care with great interest. Evidence, as they point out, has been very varied in this area but there has been a heavy preponderance for studies that have recommended against GP excision to fail to be blinded and to all be conducted by secondary care doctors. This blinded study showed that it is far from clear whether patients would be more likely to benefit from rapid primary care excision or a referral to secondary care for further assessment.

Purdy and de Berker's editorial[2] did not share my opinion. They felt that National Institute of Health and Clinical Excellence (NICE) guidelines recommending a 2-week wait referral should stand. Their argument that it is unclear if GP excision is quicker than that of secondary care is hard to support. GPs who offer minor surgery in their clinics will almost always be able to excise a lesion within the week. Secondary care may take 2 weeks just to have the lesion assessed, let alone excised.

GPs should not be excising lesions of which they are not reasonably confident of the diagnosis, and certainly not if they are not confident of clearing the margins. More thorough training may be needed for those who wish to perform this minor surgery. However, NICE guidelines should take account of Murchie *et al*'s article; patients should be offered the choice of a quick excision in the surgery or referral for a second opinion when this is appropriate. If we can promote patient choice and reduce the burden on secondary care then everyone could benefit.

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Authors' response

Johnny Wake's point is that once a GP has decided to remove something they will do it quicker than in secondary care. This was not the objective of Murchie *et al*'s study and is not a conclusion that is possible to draw from it.[1]

There are two groups of patients whose outcomes need to be considered if GPs without appropriate training are to remove suspicious lesions in primary care. First is the group of patients with lesions that the GPs may have chosen not to excise because their clinical threshold has not been triggered by making a diagnosis. The second is the group of patients whose numbers would increase if GPs were expected to excise all pigmented lesions of concern. As GPs would rely heavily on histology for clinical diagnosis, they would need to cut out a great many benign lesions. These two groups highlight the problem where entry into a clinical pathway requires diagnostic expertise. If you lack diagnostic expertise in pigmented lesions you need to cut out a great many to have enough sensitivity to not miss the melanomas. If you fall short of this then you will defer or decline to do surgery on patients and miss evolving melanomas. Cutting out the pigmented lesion should be the end not the beginning of the diagnostic pathway, and where NICE guidance is followed, the patient has the benefit of seeing a clinician experienced in the assessment of pigmented lesions enabling many to avoid surgery.

As Murchie *et al* state in their conclusions '… the relative outcomes of patients receiving their primary biopsy in primary or secondary care are unknown, although existing evidence suggests that survival is not compromised by having a melanoma excised in primary care.'

As we highlight in our accompanying editorial, this is reassuring, but the

importance of diagnostic accuracy is not diminished by these findings.[2]

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Female genital cosmetic surgery

I read with great interest the January editorial on female genital cosmetic surgery.[1]

The Royal College of Obstetricians and Gynaecologists defines female genital mutilation as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other non-therapeutic reasons.[2]

The practice of female genital mutilation is generally condemned, and under the Female Genital Mutilation Act 2003 it is illegal in the UK. However, the distinction between female genital mutilation and female genital cosmetic surgery is not clear and it could be argued that many aspects of female genital cosmetic surgery fall within the definition of female genital mutilation. After all, much of female genital cosmetic surgery is purely cosmetic with no medical benefits attached, and as Liao and Creighton point out, much of the drive behind women requesting female genital cosmetic surgery arises because there is a Western societal preference for small labia.[1]

The World Health Organization further classifies female genital mutilation into four major types. Type 2 excision includes 'partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora'[3] — does this not accurately describe labial reduction?

At a time when there is such a big international drive to stamp out female genital mutilation because it is viewed as a violation of human rights, is it right that in western countries female genital cosmetic surgery is actually on the increase? May we be seen as hypocritical in condemning countries that practice female genital mutilation if we willingly refer girls for female genital cosmetic surgery?

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GPs at the Deep End

The 'GPs at the Deep End' have the laudable aim of reducing health inequalities. Watt hypothesises there is an inequitable distribution of GPs in deprived areas.[1] He suggests that deprived areas require more GPs than affluent areas because the high disease prevalence in deprived areas leads to greater GP workload. We would like to challenge the assumption that deprivation is the main influence on GP workload. We believe at least four other factors influence this and that the four factors have complex interactions.

First, in the same issue of the *BJGP*, Salisbury *et al* found that age is associated with disease prevalence and also with consultation rates with GPs in England.[2] Therefore, GPs working in affluent areas may have an equally high workload as those in deprived areas if they have a large proportion of older patients. In Monifieth, Scotland, we not only have a large proportion of older patients but also a large proportion of patients living in care homes. The care homes we look after include a home for those with high care needs, such as survivors of head injuries. In the past these very sick patients would have been looked after in secondary care. Today, they require us to make more house visits than the average.

Second, people in affluent areas are likely to have higher social mobility. This results in families being more geographically widespread and less able to help one another. This may lead to increased dependence on health professionals such as GPs.

Third, distance from the GP and poor transport links may increase the number of house visits required of GPs in leafy affluent areas compared to their colleagues in more tightly-knit urban deprived areas. Additionally, in rural or semi-rural areas it can take well over an hour to do just one visit, and visits in a single day may be spread out over a large geographical area.

These factors may interact. For example, professional people often retire to northeast Fife to an idyllic rural location. They may have few friends and family in the area and rely on their car for transport. As they age they may become ill and require home visits due to lack of family support and poor transport links.

Finally, GPs are widely acknowledged to have an important 'gatekeeper' role. We suggest that educated, professional patients are more likely to be informed about their health and about potential treatments for illness. Retired professionals or affluent groups have often also been used to having private health care attached to their work that