

that long-term studies of their effectiveness, not just in reducing HbA_{1c} levels but in reducing morbidity and mortality, are lacking.

In view of the recent thiazolidinedione withdrawal, and that of troglitazone in the past, it is hard to develop enthusiasm for these newer agents, especially since, for many, their mode of action is to squeeze more insulin out of an already failing pancreas.

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Oral and maxillofacial surgery

At present, I am working as a senior house officer in oral and maxillofacial surgery. Our department receives a lot of referrals for dental extractions for patients who are on bisphosphonate therapy.

Bisphosphonates inhibit osteoclast-mediated bone resorption and are used in the management of metastatic cancers and osteoporosis. They have been shown to reduce bone pain, skeletal events, and improve quality of life.¹

However, the increased use of these medications has led to a correlated increase in bisphosphonate-related osteonecrosis of the jaws (BRONJ). This is a very painful condition resulting in bony exposures in the jaw that may be precipitated by any oral surgery such as extractions.

The incidence is said 0.8–12% of bisphosphonate patients who have had oral surgery. The risk increases with length of time patients are taking bisphosphonates

for and who are on IV bisphosphonates.

Due to the long half-life of these drugs, the risk of developing BRONJ is present many years after the patient has stopped taking these medications.²

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How to protect general practice from child protection

Mike Fitzpatrick's views¹ are outdated. He begins his article by mentioning the tragic cases of Victoria Climbié and Peter Connelly (Baby P): in both cases the GPs were found to be negligent. He attempts to undermine the whole system of safeguarding. It is a cynical denial of what is a very real problem.

He is right to say that we should not be driven by media hysteria; that some cases will always be missed; and that attention is needed to contentious issues such as referral forms, case conferences in surgery hours, and impenetrable minutes. The Common Assessment Framework (CAF) referral form that he describes, for which, by the way, parental consent is usually required, is under Eileen Munro's beady eye² at the moment. The CAF process was intended to help early intervention and is

evidence based.³

He advocates that community paediatricians should mediate between GPs and the child protection system, but referrals are rarely straightforward. Safeguarding issues are uncovered in the process of investigating and treating other conditions, including adult ones, and the child is not complaining. Community paediatricians do not always have the same contact with children and their families or know them well.

I am most disturbed by Mike Fitzpatrick's explanation of the nature of general practice. He describes our job as simply attempting to diagnose and treat people when we see them episodically and infrequently. He says we should not 'adopt the role of social worker, psychologist, police, or priest'. But we are to get to know our patients, their families, and their circumstances. We are to understand and care for them as whole people, not just to diagnose and treat their episodic conditions. We are GPs; gatekeepers to all the specialist treatments the NHS has to offer; and called to know, love, and care for people in the context in which they find themselves, at every stage of their lives. When a case conference is needed it would be farcical without the GP present and playing a major part.

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