

difference that patients consider important is often approximately 0.5.³ Consequently, our finding of a 0.6 mean difference between the groups is likely to be clinically significant — especially as substantial numbers of patients in the trial will have perceived more benefit than this.

Adjustment of consultation rates for the extra acupuncture consultations would not change the inference on the within — and between-group inference on consultation rates. All the 41 control patients were offered acupuncture after a period of 6 months, and 35 took up the offer. Patients from both the intervention and the control groups were interviewed.

The rationale for offering acupuncture to this group of patients is that medicine seems to have little to offer them; this mixed methods study suggests an acceptable and potentially valuable way out of what is often an impasse for doctors and patients.

Charlotte Paterson,

Senior Research Fellow, Peninsula Medical School, University of Exeter, Institute of Health Service Research, Veysey Building, Salmon Pool Lane, Exeter, EX2 4SG.
E-mail: charlotte.paterson@pms.ac.uk

Rod Taylor,

Peninsula Medical School, University of Exeter, Institute of Health Service Research, Exeter.

Peter Griffiths,

University of Southampton, School of Health Sciences, Southampton.

Nicky Britten,

Peninsula Medical School, University of Exeter, Institute of Clinical Education, Exeter.

Sue Rugg,

Peninsula Medical School, University of Exeter, Institute of Health Service Research, Exeter.

Jackie Bridges,

School of Community and Health Sciences, City University London.

Bruce McCallum,

London Institute of Five-Element

Acupuncture, 73 New Bond Street, London.

Gerad Kite,

London Institute of Five-Element Acupuncture, 73 New Bond Street, London.

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Domestic violence, PTSD, and diagnostic enquiry

It was refreshing to read a paper¹ and editorial² that sought to identify causes of patients' anxiety in their life events, as patients complain that doctors often fail to ask why they are anxious or depressed.³ The reported research identified domestic violence and abuse (DVA) as a cause of anxiety using the HARK questions (four short questions relating to Humiliation, being Afraid, Raped, and Kicked).⁴

The paper also notes that the Generalised Anxiety Disorder Scale (GAD-7) can be used as a 'case-finder' for panic-disorder, social anxiety disorder, and post-traumatic stress disorder (PTSD), as well as generalised anxiety disorder (GAD). The questions of the GAD-7 overlap with the questions required to make the diagnoses above, that is why GAD-7 can act as a 'case-finder'.¹ However, I think it is a mistake to conclude from the paper that domestic violence causes GAD, as the editorial seems to. Sherina *et al* do not claim this. They did not pursue further analysis of the type of anxiety disorder patients were suffering from in their research. Diagnostic rigour helps the doctor and patient understand the consequences of DVA and thus find appropriate solutions. Sherina *et al* discuss the association of PTSD and DVA.

A meta-analysis⁵ on the prevalence of mental health problems among those who

had experienced DVA found mean prevalences of 63.8% in 11 studies of PTSD, 47.6% in 18 studies of depression, 17.9% in 13 studies of suicidality, 18.5% in 10 studies of alcohol abuse, and 8.9% in four studies of drug abuse. Dose-response relationships of violence to depression and PTSD were observed.

The best explanatory model linking domestic violence and anxiety disorders is PTSD. It makes sense that terrifying and humiliating experiences of DVA result in nightmares, flashbacks (intrusive thoughts), avoidance behaviours, and hyper-arousal. However, a positive GAD-7 score may usefully act as a tool of communication, and a prompt to the GP for further questioning about PTSD symptoms and DVA using HARK questions.

The linked editorial² correctly identifies the lack of evidence for the use of 'routine enquiry' for DVA in general practice, as opposed to its evidence-based use in antenatal clinics.⁶ This is reiterated by the Department of Health.³ I am writing the RCGP e-learning course on DVA. I encourage GPs to work from patients' symptoms, using 'diagnostic enquiry' rather than 'routine enquiry'.⁷ The course will, I hope, provide safe, pragmatic guidance that is congruent with how we GPs work.

Fiona Duxbury,

The Leys Health Centre, Dunnock Way, Greater Leys, Oxford, OX4 7EX.
E-mail: duxburycrossel@doctors.org.uk

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Pulse oximetry in primary care

Plüddeman *et al*¹ write about the use of pulse oximetry. This seems to be one of the new trio of diseases — the other two being D-dimers for blood clots, and troponin for the detection of myocardial damage.

All three tests need to be used appropriately in their clinical situation. It seems from observation that the SpO₂ can vary significantly over a fairly short period of time, and with an error of 2% this can make a big difference to the reliability of the reading. This becomes especially true of those with chronic obstructive pulmonary disease — when their normal saturations can be really quite low.

All three tests need to be used appropriately and co-related to the clinical picture. It is very tempting to use anything numerical as having greater power than softer signs of speech, use of accessory muscles, and primarily, clinical history. Ill advised use of these tests will inevitably lead to increasing hospital admission, maybe particularly in the out-of-hours care of patients.

In assessing a patient, there are often pivotal cues, symptoms, or signs that open up the diagnosis. I think we all develop a primacy of signs, those bits of information that we rely more heavily on in making clinical decisions. We can allow something with a number attached, especially with a guideline behind it, to become the primary sign. However, I believe good general practice involves weighing up history, examination, and other data. If our action is determined by one or two bits of information I think we will lose our touch

as generalists.

Pulse oximeters are useful tools as part of our armamentarium. But if doctors continue to become more risk averse, and rely on gadgets rather than the whole clinical picture, iatrogenic disease will continue to increase.

Chris Gunstone,

36, Holly Street, Burton upon Trent, Staffs, DE15 9ET. E-mail: chris.gunstone@nhs.net

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Tips for GP trainees working in general surgery

We welcome the recent very helpful article from Smith *et al*¹ which has broad relevance to all those who are not career surgeons when they embark on their surgical attachments. This article sensibly recognises there is often more than one way to investigate and, for instance when considering renal colic, offers wise advice that will limit unnecessary exposure to radiation.

We cannot, however, agree with the advice, 'If unsure whether an erect chest X-ray and abdominal X-ray is warranted, get one anyway.' Exposure to potentially unnecessary radiation should not be ignored and an abdominal X-ray in the context of abdominal pain is one of the most overused plain films,² with each abdominal X-ray being equivalent to approximately 35 chest X-rays.³

Selection of the most appropriate imaging is often difficult, and guidance, such as *Making the Best use of Clinical Radiology Services*⁴ produced by the Royal

College of Radiologists, can be extremely useful in this setting. This document is available online throughout the NHS, is evidence based, and provides guidance both as to which investigations may be helpful in each clinical context, and provides a reference if you are asked to justify why you did not feel a particular investigation was appropriate. Radiologists are also generally very happy to offer advice on what is appropriate and may be a useful port of call if you find yourself being asked to request investigations routinely that do not clearly conform to such guidelines.

We suggest adding a point zero: always think for yourself. Seek advice when you need it, but be prepared to justify your own actions.

JA Allred,

Foundation Year 1 Doctor (Radiology),
Radiology Department, Royal Cornwall
Hospital, Truro TR1 3LJ.
Email: james.allred@rcht.cornwall.nhs.uk

RD Proctor,

Consultant Radiologist, Radiology
Department, Royal Cornwall Hospital,
Truro TR1 3LJ.

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