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Leonardo da Vinci

I suppose that many of us would choose to have known Leonardo da Vinci of all possible historical figures. I count myself most unfortunate, therefore, to have missed the opportunity when I read in the first lines of the June *BJGP*¹ that 'It's almost exactly half a century since Leonardo da Vinci made his beautiful drawings of the heart valves'. I would have been 19 at the time, by your reckoning, and would have saved what I could from my student allowance to hasten over to Italy for the privilege of sitting at the feet of the great man. Pity, opportunity missed ... sadly.

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Low-level exposure to carbon monoxide

The diagnosis of chronic, low-level exposure to carbon monoxide (CO) remains an enduring challenge for physicians worldwide.^{1,2} A colourless, odourless, and tasteless gas, CO is undetectable by exposed individuals.³ At the same time, as a product of incomplete combustion of carbon containing compounds, it may be readily produced in domestic settings where fossil fuels (coal, oil, gas) and wood are used.³

The UK Department of Health (DoH) recently provided an estimate of 4000 attendances to emergency departments (EDs) due to CO poisoning and around 50 fatalities annually⁴ due to accidental exposure. Every year approximately 250 000 gas appliances are condemned in the UK; if only a proportion of these were emitting CO then the true numbers of CO poisoning are likely to be considerably higher.⁵

The difficulty in recognising cases of low-level exposure has been well documented in

the literature.^{1,2,6,7} This is mainly on account of the non-specificity of symptoms with which cases may present, such as headache, flu-like illness, fatigue, difficulty concentrating, and diarrhoea. Although the majority of presentations to primary care with such non-specific symptoms will probably not be cases of CO poisoning, prompt identification of patients in whom symptoms are due to CO exposure is clinically very important so systems can be put into place to minimise further harm.

To aid management of CO-poisoning cases in primary care, we propose 'COMA', an *aide-mémoire* to quickly identify cases of possible CO poisoning as well as a teaching aid for junior staff. Four questions to be asked to patients can be remembered by the acronym 'COMA':

C: Cohabitees/companions: is anyone else in the property affected (including pets)?

O: Outdoors: do your symptoms improve when out of the building? (better outdoors)

M: Maintenance: are your fuel-burning appliances and vents properly maintained?

A: Alarm: do you have a carbon monoxide alarm?

We hope that this *aide-mémoire* can be of use in raising awareness of CO poisoning in general practice and that its brevity and ease of use will make it a useful frontline tool in the identification of chronic cases of CO poisoning.

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Do GPs really provide 47 minutes a year for the patient?

The recently published RCGP report on medical generalism brings into focus the need for GPs to spend more time with patients to deliver high quality generalist care.¹ Historically, the figure of 47 minutes a year for the patient has been widely cited and discussed as a summary statistic for the total consultation time a GP spends with each patient per year.^{2–4} This figure was first proposed in 1998 by Professor Sir Dennis Pereira Gray as a challenge to the '7-minute consultation' summary statistic of the day.⁵ The figure was based on a calculation using data from the Doctors' and Dentists' Review Board (DDRB) workload survey and the General Household survey (GHS), now known as the General Lifestyle survey (GLS).^{6,7}

Average consultation length (DDRB) x
Average number of consultations per year
(GHS)
= Total time with patient per year

The DDRB consultation length figure is