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Editor's choice

An end to depression in primary care?

I enjoyed Moscrop's essay.¹ As a GP Trainee in the early 70s with an interest in the psychological I was taught to distinguish between endogenous depression (no evident trigger, serious, chronic, more likely to respond to antidepressants) and reactive depression (for example, triggered by bereavement, relationship breakdown, or job loss, and less likely to respond to antidepressants). Inspired by the works of Michael Balint and Colin Murray Parks I tried to offer a listening ear to troubled patients in long appointments at the end of normal surgery times. There were inevitable disappointments, such as the newly-widowed lady who came to see me weekly over several months who plaintively asked on her last visit 'So am I not getting any pills?' An early addition to my Patient's Unmet Needs list.

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REFERENCE

1. Moscrop A. An end to depression in primary care? *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X654669.

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On your bike!

Thank you to Annie Elkins for an entirely convincing article on the benefits of cycling as a GP.¹ A solid evidence-based argument for incorporating regular cycling in to the working life of a busy GP is well presented. I can add to the impetus behind this message by reporting that cycling has massively boosted my enjoyment of my working day. Cycling to work every morning leaves me feeling invigorated on arrival, and travelling home is a fantastic way to unwind. If you are considering taking up cycling during your working day, the challenge that you

will face is that of establishing an entirely new routine that may involve changing clothes at work, showering at work, buying specialist rain gear, and finding somewhere safe to park your bike. Establishing the routine that works for you takes time. Perseverance and lateral thinking on ways to achieve a routine that suits you will pay incredible dividends. Annie Elkins suggests purchasing a pooled practice car for home visits. Can I add the suggestion of a pooled practice bicycle that all staff can use for running errands and attending to house calls?

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REFERENCE

1. Elkins A. On your bike! *Br J Gen Pract* 2012; **62(602)**: 482.

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Predicting risk of bladder cancer in the UK

We were interested to read the paper by Shephard *et al*¹ on the clinical features of bladder cancer in primary care, as we have previously published a paper² in the *BJGP* where we reported on symptoms associated with renal tract cancer (of which around 80% were bladder cancers) in primary care. Both studies evaluated the risk or positive predictive value of symptoms for detecting cases of cancer, and both used UK primary care databases, but the study designs were different with Shephard *et al* using a case-control approach while we used a cohort design.

A key finding of both studies is that haematuria is a strong predictor of bladder/renal cancer, with a stronger association at younger ages. Indeed we reported that around three-quarters of renal cancer cases had reported haematuria before their diagnosis. Both

studies also found at least a doubling of risk in people consulting with abdominal pain. A strength of our study design was that we were able to combine the risks associated with the different symptoms and clinical features with the established risks associated with smoking, into an algorithm that can predict absolute risk in individuals presenting with symptoms. We also accounted for the steep increases in risk with age and for different risks in men and women, since rates in men are at least three times higher than in women. Crucially we validated this algorithm in a separate cohort of patients, and found that it discriminated extremely well between cancer cases and the remainder of the cohort (ROC values of 0.95 in men and 0.91 in women). The 10% of patients with highest risks contained 87% of all renal cancers diagnosed within 2 years. It is unclear how many cancer cases would be detected using the approach of Shephard *et al*, nor is there any validation on an external dataset which is an essential step needed to determine whether the results are valuable.³

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JH-C is professor of clinical epidemiology at the University of Nottingham and co-director of QResearch, a not-for-profit organisation that is a joint partnership between the University of Nottingham and EMIS (leading commercial supplier of information technology for 60% of general practices in the UK). JH-C is also director of ClinRisk, which produces open and closed source software to ensure the reliable and updatable implementation of clinical risk algorithms within clinical computer systems to help improve patient care. CC is associate professor of medical statistics at the University of Nottingham and a consultant statistician for ClinRisk.