A gastrograffin swallow was arranged, by which stage the patient was struggling to swallow his saliva. Gastromiro was used and the procedure identified almost complete obstruction at approximately the distal one-third of the oesophagus. Gastromiro is a water-soluble contrast agent and was chosen because it is easier to swallow than barium, and is non-toxic. An urgent OGD identified retained food and fluid in the oesophagus. Linear furrows and concentric ring constrictions were noted in the oesophagus at OGD. Multiple random biopsies were taken and had been found to be diffusely infiltrated with eosinophils, consistent with a diagnosis of eosinophilic oesophagitis.

This article and subsequent case have significantly increased my awareness of this condition and brought it to the forefront of my mind when considering differential diagnoses of food boluses.

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REFERENCE

DOI: 10.3399/bjgp12X658197

Liquid nitrogen for cryotherapy

The West Lothian Community Health and Care Partnership along with the local pharmacy department have unilaterally decided that they will no longer supply practices with liquid nitrogen for cryotherapy. The liquid nitrogen had been supplied for over 20 years to our practice. Pharmacies with liquid nitrogen for cryotherapy.

The main driver seems to be cost, however practices can obtain Histofreezer® 150 ml dimethyl ether/propane/iso butane aerosol on stock order in Scotland. This costs approximately £50 for 50 applications. Histofreezer reaches a temperature of −55°C within 15 seconds. There seem to be very few papers on this subject, however one from Madrid suggests it may be useful and I would be interested to hear of other GPs’ experiences.

However I feel the withdrawal of liquid nitrogen will result in more referrals to dermatologists.

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DOI: 10.3399/bjgp12X658214

Confirming death in general practice

Kelso et al from Dumfries & Galloway raise the issue of ‘confirming death in general practice’. This is an area that is inadequately addressed in undergraduate and postgraduate training. Similarly the certification process following confirmation of death is similarly neglected. There is often a difference between confirming death at a patient’s home and in a hospital as a hospital doctor is working in an acute setting where death may be sudden, with the need for a decision whether or not resuscitation is required and appropriate. Furthermore, in general practice, nurses are being trained in some parts of the UK to confirm death out-of-hours.

Every few months there is a global report in a newspaper of a patient ‘waking up’ in a mortuary where death has been mistakenly confirmed in circumstances of conditions that can induce coma. This led to my writing an editorial in the BMJ in 1996 on the subject of ‘diagnosing death’ and similarly concluded that this is a subject rarely mentioned in modern textbooks, although much is written about pronouncing brain death. In this editorial I provided guidelines for practitioners, as for many this process has fallen into a ‘commonplace formality’. In my days as a hospital doctor and a GP there was often considerable doubt about the actual moment of death, particularly for those witnessing the process of dying, as the warmth of the body and the long unnerving intervals between respiratory gasps can be misleading.

The authors ask how the process may be improved. Perhaps consideration could be made for this to be a mandatory Direct Observation of Procedural Skills (DOPS) for both Foundation Doctors and Associates in Training for General Practice based on the 2008 Academy of Royal Colleges code of practice for confirmation of death.

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DOI: 10.3399/bjgp12X658223

Hidden gem
David Kernick’s rather unpromisingly titled *Theoretical framework for multimorbidity* is a hidden gem punching far above its weight. Don’t be deceived. It repays careful and repeated reading and reflection, an effort well rewarded. The theory is apposite and cutting-edge, pulling together many threads in current generalist thinking in and out of general practice both lucidly and with a constant eye on how they can be useful in practice.

The systems theory model (metaphor, heuristic) of simple-complicated-complex systems, is fairly well known for Martin Marshall for example, but is here extended to include those ideas from chaos and complexity that have proved such useful tools in the consultation and in healthcare delivery, principally around the idea of complex adaptive systems. There are also echoes of those other tripartite ideas, the Hippocratic ‘cure sometimes, relieve often, comfort always’ and Heath and Sweeney’s Technical, evidentiary, and reflective generalism. Kernick picks up the point which was nagging me, that perhaps it is the simple that is a special reductionist case of the complex and chaotic rather than the reverse. He also picks up in his conclusion on the political implications, both governmental and Foucauldian.

It was especially good to read this in the generalist context of your editorials and the articles of Martina Kelly1 and Emyr Gravell,3 and good to note that reflective general practice is still alive and well in Exeter.

Hippocrates
In 1972, Hopkins wrote in your Journal about his trip to the island of Kos in Greece, where he had visited the tree of Hippocrates.1 According to the myth, this plane tree was planted in 500 BC by Hippocrates himself, who used to teach in the shade below the branches of the tree. The tree continues to grow and now, 40 years later, crowds over a Turkish fountain, which was built adjacent to it in the 18th century.2 As the field of medicine has grown over the years, so has the Tree of Hippocrates, and pillars had to be erected in order to support the growing branches.

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DOI: 10.3399/bjgp12X658241

The Hippocrates tree.