Letters

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Editor's choice

Child care in general practice

May I, as a retired children's physician married to a GP and the nephew and grandnephew of family doctors intrude on your pages, first to applaud Dr Iona Heath's appreciation of my friend Dr John Horder and second to express my whole agreement with what your editorial[1] has to say about the role of GPs in the care of children. I may in this context extend Winnicott's aphorism that 'there is no such thing as a baby — rather a nursing couple' — to older children, whose existence depends on being part of a family (which is why I prefer the title of family doctor for your speciality rather than GP). A paediatrician is an American species of GPs for children which I am sorry to say is what the College of Child Health seems to favour; with the corollary that they see parents as agents against whose ministrations (one remembers Larkin's memorable but unprintable lines) children need the protection of doctors. It is my long experience that nearly all parents, except psychopaths, naturally want to do their best for their offspring, but instead of providing them with what they feel they themselves lacked as children, they can only give them what they got, which is all they have to offer. They need help, not prosecution, since most children would prefer to remain with their parents (those who have taken on their role) rather than be abandoned to the tender mercies of being 'in care', provided that the family in which they belong is adequately supervised. Infanticide is another matter not to be confused à la Meadow with abuse. My first contact with John Horder was the result of a mutual interest in the paediatric education of recruits to family practice ('training', as Winnicott once remarked, is for privates with the foot guards, performing animals, and jugglers!): an education in the norms and abnormalities of growth and development involving both psyche and soma, and including illness and what to do about it (I well remember a Paddington GP who when knocked up at night by a mother worried about her baby shone a torch in its face from his bedroom window and wrote on the back of a cigarette packet 'run to Paddington Green' [the baby had meningococcal septicaemia]). As for the relevance of neonatology I well remember what a torture it was for my dying wife to submit to many a failed venepuncture until one day a GP in training got it in first time. When I asked him where he got this skill, he replied — 'in your neonatal unit, don't you remember me?' (And could it be that the basic science of psychology is social anthropology?). One last thought ... why not attach a community paediatrician to every practice — not necessarily as a full-time principal?

John Davis,

MD, FRCP, FRCPCH, 1 Cambridge Road, Great Salford, Cambridge, CB22 5JE.

REFERENCE

1. Saxena S, Francis N, Sharland M. Primary care of children: the unique role of GPs. *Br J Gen Pract* 2012; **62(602):** 340–341.

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The eagle is landing

As a GP in Edinburgh, I read with great interest the article 'The eagle is landing,' in your September 2012 issue.[1]

Some 12 years ago, I was diagnosed with glossopharyngeal neuralgia, secondary to Eagle syndrome. The saga started quite simply during a family holiday, with a discharging ear infection treated with ciprofloxacin. I saw three consultant ENT surgeons, for ear pain radiating to the back of the throat, and swallowing difficulty. I also saw a general physician for nausea, an ophthalmologist for blurred vision, and a neurologist for tingling of the tongue associated with difficulty in articulation. The pain and weight loss resulted in my being unable to practice for 4 months.

I was investigated, with blood tests, MRI, and CT scans which were all reported normal, hence the very uncomfortable situation of 'medically unexplained symptoms'. As a GP this was particularly bewildering and professionally undermining. The diagnosis of Eagle syndrome was finally made by a consultant radiologist following a re-referral to neurology some 15 months later.

The aetiology is, in my case, unclear. I personally suspect that the ciprofloxacin and/or the ear infection may in fact have caused some calcification in the stylohyoid ligament. What further complicated my case was that repeated treatment with ciprofloxacin seemed to help the undiagnosed neuralgic symptoms. This remains unexplained.

The lack of knowledge of this condition in all the clinicians involved (including myself) lead to an inability to recognise the clinical features and delayed the diagnosis. However, on a positive note this did allow time for natural resolution of symptoms over 2–3 years.

My experience was a humbling one, and I feel that I have more empathy with other patients who have medically unexplained symptoms. Although I consider mood disorder in such patients, I do accept that an unknown physical aetiology may be present.

Following my experiences, I was left wondering how many cases I had potentially missed. Over the last 10 years I have considered the diagnosis in only two or three patients and not diagnosed any patients with Eagle syndrome. Therefore, my personal opinion is that this is a rare condition. The symptoms, that can range from distressing to life threatening, and cross several specialities, make Eagle syndrome a difficult diagnosis. I would certainly welcome further awareness, research on aetiology, management, and natural history of this interesting condition.

Janet Oswald,

Colinton Surgery, 296B Colinton Road, Edinburgh.
E-mail: Janet.Oswald@lothian.scot.nhs.uk

REFERENCE

1. Zeckler S-R, Betancur AG, Yaniv G. The eagle is landing: Eagle syndrome — an important differential diagnosis. *Br J Gen Pract* 2012; **62(602):** 501–502.

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Altruism

I can half agree with your comments, but not the other half.[1] Your quote from Aneurin Bevan can be interpreted in various ways, in particular, many terminal patients have stated that they would prefer to expire in 'a gush of warm sympathy' at home or in