accessible to inform everyday decision making and GPs need to benchmark their own understanding and tolerance of risk and make this clear when they make recommendations to patients.

If patients can make sense of their risk they will make more informed and personal choices about their care (and may often decline care).

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Family medicine in Africa

Our fellow generalists have shown realism and honesty combined with academic rigour about the difficulties they face in establishing family medicine in Africa (except in South Africa). The tendency to hope that family medicine will fill the gap is understandable in a continent with such a huge shortage of healthcare workers[1] but it sounds as if family medicine in Africa is drifting into becoming a hospital-based specialty and its links with its 'spiritual home' in primary care are becoming severely stretched; as evidenced by the comments from Kenya.

Now More than Ever[2] promoted universal coverage, services based around peoples' needs and healthier communities, which are all best addressed in services outside hospitals. Starfield argues for better primary care services for economic[3] as well as moral reasons[4] and de Maeseneer, although strongly supportive of family medicine in Africa, argues consistently for increasing development of primary care provision, especially through the 15by2015 initiative.[5] Finally the looming increase in burden of disease due to non-communicable diseases, that by 2030 in low income countries is predicted to increase to over 50% of the overall burden,[6] will be best dealt with in primary care. Thus my question is: 'does family medicine in Africa need to re-evaluate the direction it's being drawn into and consider placing itself more strategically in the community?'

Repositioning itself more obviously in the community may also help family medicine to be more distinctive and better understood by others (colleagues as well as patients). This is especially true for training, the goal being to achieve the aspirations as set out by Reid,[7] that reach well beyond performing procedures in hospitals. UK generalists have decades of experience training outside hospitals and it may be an area for collaborative work. One possible way the NHS/RCGP could offer support would be to release (and financially protect) some appropriately experienced GP trainers to support carefully selected family medicine training programmes in Africa by providing a training component in the community as an alternative to hospital-based training; this is generally not happening at the moment: in some cases 35 out of 36 months training are in hospital.

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Frostbite developing secondary to cryotherapy for viral warts

A 15-year-old male was referred by his local accident and emergency (A&E) department with dark blistered lesions over the sole of his left foot and palms of both hands. Eight days prior he had received cryotherapy treatment for viral warts by his GP.

Two days after the initial procedure the patient requested an emergency appointment at his general practice because of intense pain over the treatment sites and feeling generally unwell. He was informed the pain was a normal side effect of the treatment and was likely to last no more than 10–14 days. Four days later the patient, with worsening pain and feeling unwell attended an out-of-hours GP. The treatment sites were noted to have progressed into substantially larger lesions compared to the initial size of the warts. He was told to arrange an appointment with his own GP the following day for further review and urgent referral to the trauma and orthopaedics team.

The following day, after review in A&E, he was referred to the wound clinic at the hospital for the following day. On attendance at this clinic, now some 8 days post-procedure, the examining doctor made an urgent referral to the burns and plastic department for advice about further management given the unusual appearance and size of the lesions. The patient attended our department the same day.

On examination, dark grey/black fluctuant blistered areas were noted over the head of the metatarsal of the left great toe as well as overlying the calcaneum. Similar lesions were seen over the palm, volar index finger, and volar thumb of his right hand and over the palm and volar thumb of his left hand (Figures 1, 2, and 3). The overlying skin was cold to touch and insensate. The necrotic skin overlying the initial cryotherapy sites were noted to be many times larger than the initial wart lesions, that were described by the patient as being 'tiny' compared to the blistered areas. A diagnosis of frostbite secondary to cryotherapy was made. The wounds consisting of necrotic skin (epidermis and