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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DOI: 10.3399/bjgp13X667105

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 workers¹ 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 economic³ as well as moral reasons⁴ 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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DOI: 10.3399/bjgp13X667114

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

Figure 1. Frostbite secondary to cryotherapy treatment.

Figure 2. Frostbite secondary to cryotherapy treatment.

Figure 3. Frostbite secondary to cryotherapy treatment.

dermis) were debrided to healthy dermis, cleaned with an iodine-based antimicrobial agent, and dressed with burn dressings. After this procedure, the patient felt instant relief of his symptoms and was discharged home with analgesia. He was seen in our outpatient burns dressing clinic where the wounds continued to heal well.

Cryotherapy is a well-established treatment for viral warts with many procedures carried out in primary care. While freezing the lesion is the intended mechanism of treatment, freezing the lesion for prolonged periods or too close to the lesion is likely to cause deep burns that extend over a larger surface area than the initial lesion. Care must be exercised when using such devices and correct instructions followed. Despite being a common tool for treatment of benign lesions, the patient ought to be made fully aware of all side effects associated with such treatment so that informed consent is given. Despite being provided with an information sheet on cryotherapy both the patient and his mother felt (retrospectively) that this provided inadequate information about what to expect.

Additionally, although the patient reported being asked by his GP if he consented to both hands being treated on the same admission, we would not advise this given the limitations this may have on activities of daily living.

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DOI: 10.3399/bjgp13X667123

Corrections

The no-difference line in Figure 2 and the y-axis were incorrectly published in an article from the February 2013 issue of the journal: Martin, *et al.* Inter-arm blood pressure differences compared with ambulatory monitoring: a manifestation of the 'white-coat' effect? *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X663055. The correct figure will be available online. We apologise for these errors.

DOI: 10.3399/bjgp13X667132

The author Liz Mitchell has been changed to Elizabeth D Mitchell in the November 2011 issue: Browne *et al.* Patients' needs following colorectal cancer diagnosis: where does primary care fit in? *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X606582. The updated version of this article will be available online.

DOI: 10.3399/bjgp13X667141