All letters are subject to editing and may be shortened. General letters can be sent to bjgpdisc@rcgp.org.uk (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication. For submission instructions visit: <http://www.bjgp.org/letters>

Editor's choice

I read with great interest the article on encouraging adolescents to contact their GP. The research describes an increase in young people, especially young men, accessing general practice following an informative, personal letter to 16-year-olds from their GP. The RCGP Adolescent Health Group (AHG) has also recognised the importance of informing young people about general practice. However, we also recognise the many pressures that general practice is under and understand that formulating such a letter with a young people's focus group may not be feasible for individual practices. We have therefore designed leaflets for young people and their parents/carers explaining confidentiality and general practice in the context of young people's health concerns. The leaflets contain an editable box in which practices can add their contact details, surgery times, and information about young people's services. A small focus group working with one of the AHG members suggested the leaflets should be sent to young people around the age of 13–14 years but practices can decide this depending on the needs of their practice population.

The leaflets can be downloaded from the RCGP website and are also available via www.patient.co.uk.

We would welcome feedback from any practice that use the leaflets: please send your comments to the AHG secretary (s.dawlatly@nhs.net). If you would like a sample of a covering letter that practices may use to send out with the leaflets please contact me.

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Investing in primary care

I am and always have been in complete favour of investing in general practice to expand capacity to manage both urgent care and planned care that presents to us increasingly in our work. To that extent Dr Baker and the RCGP are uncontroversial in wishing to have an 11% increase in investment. Indeed I have suggested a 12% shift of resources to primary care. Where the RCGP and its leadership are naive is in how this investment should be achieved. There is no new money, nor is there likely to be in the foreseeable future, whichever government takes over. So we need to shift activity out of hospital care to do this. In practice that means doing what we are doing in Central Manchester, and invest £1.4 million in extending primary care so that people can be seen there when they need to be seen. This means absorbing the urgent care demand, as well as the planned and long-term conditions demand on primary care. Here is an example of where meeting the needs of the people coincides with the needs of general practice and the NHS. Everyone is a winner.

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Carpal tunnel syndrome

Carpal tunnel syndrome is a common problem, which we encounter regularly in our GP consultations.¹ Accurate history taking and examination, as mentioned, can contribute in up to 70–90% of cases to a patient diagnosis.^{2,3} The authors¹ presented a decision tree incorporating the Phalen's test as a diagnostic tool, which has a low diagnostic sensitivity (57%) and specificity (58%). Hansen *et al* even describe the Phalen

test as being 'useless'.⁴ Phalen test, Tinel sign, presence of thenar atrophy and history of nocturnal paraesthesia have little diagnostic value compared with history taking (84%) sensitivity/specificity 0.33%) and examination findings, for example weak thumb abduction (sensitivity 66%, specificity 66%). Nerve conduction studies can be used in patients with an intermediate pretest probability or in patients with an atypical presentation. They can also be used to quantify and stratify disease severity to aid in further treatment decision. In patients with a high probability of a carpal tunnel syndrome based on history and physical examination, nerve conduction studies are generally not indicated.

Evidence-based physical examination and history taking combined with clinical reasoning will improve the diagnostic outcome of consultation in general practice and will improve patients care and reduce unnecessary diagnostic testing. This will improve and speed up patients' care and will save the NHS money in the long run. Teaching of evidence-based physical examination and clinical reasoning need to be formally introduced into the medical student's curriculum.⁵

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