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Editor's choice

The article in the *BJGP* June edition advised that people with bleeding varicose veins should be referred immediately. Might I suggest elevation and compression is the initial management. This may seem obvious but there will be the risks of this article being taken at face value. It also recommends referring superficial vein thrombosis. Is this the new name for thrombo-phlebitis? If so may I suggest one needs to rule out underlying DVT (superficial thrombosis may lead to a rise in D-dimer) and check for signs of underlying malignancy. Also recommended is referring any venous ulcer that has not healed within 2 weeks. Have the authors ever seen a venous ulcer that does heal within 2 weeks? We are being encouraged to reduce unnecessary referrals.

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Effect of Ramadan fasting on emergency walk-in-clinics in Jordan

Ramadan is the month of fasting for Muslims; they fast from dawn to sunset. I studied patients attending walk-in-clinics in the emergency department of Al-Bashir Hospital¹ during the month of Ramadan 2010, 11 August to 9 September. A total of 7770 patients attended: 2566 (33%) attended in shift A, 8:00–18:00 hours (divided in two sessions), 2124 (27%) in shift B, 18:00–23:00 hours, and 3080 (40%) in shift C, 23:00–8:00 hours. There were 4198

(54%) males and 3572 (46%) females, with a male:female ratio of 1.17:1. There were 1951 (25%) patients aged 1–5 years and 6458 (83%) aged 1–40 years. Patients of <1 year old are admitted directly to the paediatric emergency room. The main presenting complaint was upper respiratory tract infection in 1889 patients (24%), followed by acute simple gastroenteritis in 1313 (17%), abdominal pain in 726 (9%), skin problems in 456 (6%), renal problems (urinary tract infection and renal colic) in 443 (6%), and 224 (3%) requesting sick leave. A total of 724 (9%) were referred back to on-call teams. In Ramadan, young patients with upper respiratory problems were the main attendees, and shift C was the busiest.

I was able to compare these figures with observations made in the same clinic over a 1-month period earlier in the year (18 April to 17 May 2010), during which time 10 000 patients consulted. The age and sex distribution of attendees during Ramadan was similar to this period, but the proportion of patients attending during shifts B and C was almost reversed: 27% and 40% respectively during Ramadan compared with 43% and 24% during the earlier observation period. The main reasons for attendance were also similar in both cohorts.

These findings are surprisingly similar to data collected in the UK. Salisbury and Munro's review article in 2002,² concluded that young patients with minor problems, mainly upper respiratory symptoms, were the main attendees for walk-in-centres. Dale and co-workers³ at King's College School of Medicine and Dentistry concluded that young patients with minor problems were also the main characteristics of primary care patients attending the emergency department. However, the constraints of Ramadan appear to modify the timing of the presentation of these problems, but not their frequency.

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Access, continuity, or both

The Royal College of General Practitioners seems to wish to promote continuity over accessibility.¹ However, continuity and access are not mutually exclusive. Sometimes patients or parents have to make a trade-off between speed of appointment and choice of doctor. Those with a new problem, children, and those who work, prefer speed. Those with long-standing physical illness, women, and older people, prefer their own doctor. In any case, establishing and maintaining a relationship with a clinician depends on having ready access to them.

There is only equivocal evidence on the relationship between continuity and patient outcomes.² Seeing the same doctor does not guarantee a good relationship! Dr Harold Shipman is a well-known example of how things can go very wrong. Indeed a particular risk of continuity is of collusion, for example in sickness certification or of perpetuating pathological behaviours.³ On balance, the benefits of relationship continuity appear to be better supported by research than the risks. On the other hand, generally speaking, practices that perform well on delivering a good experience for their patients also perform well on measures of clinical quality.⁴ Better access consistently showed the strongest link with the process and outcome indicators of quality.

One study found that better access to primary care was correlated with higher QOF scores, and lower rates of emergency admission,⁵ and another with lower emergency department utilisation.⁶ Another study found delayed first diagnosis of cancer⁷ with poor access.

The debate should no longer be about either access or continuity, but how both are delivered. This will involve investment in