Letters

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Editor's choice

As a GP trainee I recently attended the 2014 London GP Trainee Conference. Prominent in the programme were the Excellence Awards. I marvelled at the achievements of some of my colleagues: dazzling research projects, numerous publications, and successful large-scale public heath campaigns overseas.

But some of us wondered about the true nature of excellence in general practice. Should we really be celebrating these outstanding successes with Excellence Awards? Is it possible that they may come at the expense of true proficiency at the Royal College curriculum? Perhaps it is the humbler trainees who concentrate on core general practice, who may be more on track to meet the needs of their patients.

As a doctor my CV may never match those of the award winners, but as a patient I know which type of GP I might prefer to see.

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Skin cancer excision performance in Scottish primary and secondary care

I agree with the authors view that a secondary care specialist, supported by a multidisciplinary team within the hospital, will excise skin cancers with a greater degree of skill than the average GP.[1] This seems obvious. What is much less clear, however, is whether this incremental technical quality, achieved at considerable cost, is truly clinically meaningful. This is the key issue to be addressed if the debate reinvigorated by this article is ever to move forward.

The authors raise several valid methodological issues with our own previously published and related work. They are right to do so. Our work is flawed and provides no definitive answers. Unfortunately, however, they have not themselves improved on our approach and their results offer no new insights. Particularly, it appears that pathology reports were audited without blinding as to the source (primary or secondary care). This compounds the flaw of nearly all earlier work except our own 'anomalous' results. The potential for partial auditors to favour their own in this type of analysis is too important a source of bias to ignore. Additionally, the decision to compare 1 month of secondary care data with a year of primary care data is not properly justified and seems idiosyncratic. The shorter period of observation for secondary care in the study may further bias the results in favour of secondary care operators. Furthermore, they have made no allowance for different levels of experience among GP excisers.

These data are unconvincing and I do not believe they take us any further forward. As we have repeatedly stated, a prospective randomised trial is needed. Only then will we have the high quality evidence on which to base future guidelines and the best models of care for patients.

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1. Haw WY, Rakvit P, Fraser SJ, *et al.* Skin cancer excision performance in Scottish Primary and Secondary Care. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X680929.

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GPs' skin cancer excisions

I am a GP with a special interest in skin cancer, and have been excising basal cell carcinomas (BCCs) in the community within the Oxfordshire Community Dermatology Service since 2010. My incomplete excision rate over this 4-year period is 1.7%, as is that of the GP colleague who works with me. Approximately half of the lesions we excise are on the head and neck. There are other GPs with surgical aptitude who would love to work in our service but are unable to undergo the costly (to themselves and their practices) training and accreditation process required by the National Institute of Health and Care Excellence guidelines. How can they demonstrate competence through audit data, when they are not allowed to perform the procedures in the first place? Rather than using this study[1] as evidence to implement a similar guideline in Scotland, I would encourage commissioners there to engage with GPs with surgical aptitude, get them trained to a suitable standard (in conjunction with their local dermatologist and skin cancer multidisciplinary team) and encourage their colleagues without such aptitude to refer the patients with low-risk BCCs to them.

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1. Haw WY, Rakvit P, Fraser SJ, *et al.* Skin cancer excision performance in Scottish Primary and Secondary Care. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X680929.

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Authors' response

We value the contribution from our GP colleagues in medical and surgical dermatology, and are keen to support safe, high standard, evidence-based patient care. We accept that further studies on skin cancer excision are needed. If practical experience or adherence to management guidelines correlates with excision results, we will have an evidence base to develop primary care management in Scotland and perhaps stimulate reassessment of National Institute of Health and Care Excellence guidance.

In terms of bias, the pathology reports are factual, and reported by pathologists,

who are not dermatologists, GPs, or plastic surgeons. Sequential reports were analysed by a medical student, with no specific links to primary or secondary care. However, we agree with Dr Murchie's suggestion that a year of secondary care data compared against a year of primary care data has merit, although actual numbers would then have been different by over a factor of 10, making data collection and comparison challenging. A month of secondary care data gave roughly equivalent numbers to a year's primary care, making comparison easier.

We feel that our study provides a useful overview of current practice in primary and secondary care, over a wide population in Scotland. The surgical management of non-melanoma skin cancer in Scotland is not subject to guidelines, in contrast to England and Wales. We appreciate the constructive comments from Dr Chambers, and agree that the training, experience, and ability of individual GPs performing skin cancer surgery in Scotland will vary and that there will be some GPs who practise to a high standard with excellent results. Regular clinical audit of outcomes after skin cancer surgery in both primary and secondary care is essential.

We are pleased that our study has encouraged debate and further research. It also provides a benchmark for dermatological surgery practitioners to compare outcomes against those of their peers. The recently published SIGN guideline *Management of Primary Cutaneous Squamous Cell Carcinoma* may alter practice,[2] and we believe our study is timely in documenting practice before its introduction.

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1. Haw WY, Rakvit P, Fraser SJ, *et al.* Skin cancer excision performance in Scottish Primary and Secondary Care. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X680929.
2. Healthcare Improvement Scotland. Scottish Intercollegiate Guidelines Network (SIGN). *Sign 140. Management of primary cutaneous squamous cell carcinoma. A national clinical guideline.* http://www.sign.ac.uk/pdf/SIGN140.pdf (accessed 10 Sep 2014).

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First do no harm

The RCGP's week-by-week guide to pregnancy (*Emma's Diary*) advises that 'a family with a history of nut allergy should avoid giving foods containing nuts until their baby is at least 3 years old', but current thinking is exactly the opposite. Instead of restricting exposure to peanut protein during weaning, there is evidence that, rather than causing sensitisation, early exposure to peanuts may actually induce tolerance and prevent the abnormal immune response that causes an allergic reaction.

Several research publications in the last 10 years suggest that strict allergen avoidance (peanut, wheat, egg, and tree nuts) may not be an effective way of preventing the development of food allergy in high-risk families. Early life exposure may lead to tolerance not sensitisation, perhaps explaining why Jewish children in the UK have a prevalence of peanut allergy tenfold higher than those in Israel where peanut is used as a weaning food.[1]

While we are not quite ready to give large amounts of peanuts to children at high risk of developing nut allergy, international guidelines for primary prevention of food allergy have been recently updated to advise families to start weaning at 4 months, and to introduce complementary foods for all infants including those at high risk of developing allergic conditions due to parent and/ or older siblings with allergic disease.[2]

Food allergy is not yet fully understood, but in the interim we need to ensure that the advice we give to our patients is beneficial or neutral, but not potentially harmful.

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2. Muraro A, Werfel T, Hoffmann-Sommergruber K, *et al.* on behalf of EAACI Food Allergy and Anaphylaxis Guidelines Group. EAACI Food Allergy and Anaphylaxis guidelines: primary prevention of food allergy. *Allergy* 2014; **69:** 590–601.

DOI: 10.3399/bjgp14X681733

Correction

In the June editorial Stange K, Burge F, Haggerty J. RCGP Continuity of Care Toolkit: promoting relational continuity. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X679957 the acronym in the title was incorrectly shown. We apologise for this error and have corrected the online version.

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