

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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DOI: 10.3399/bjgp14X681721

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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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.

DOI: 10.3399/bjgp14X681745