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: bjgp.org/letters

Editor's choice

The second RCGP Health and Justice conference was held at Rampton this September. The consensus position of the conference agreed that more can be done to help prisoners who reach the end of their lives while imprisoned. Both Rampton Hospital and Whatton Prison demonstrated the excellent end-of-life care facilities which they have developed to treat prisoners who choose to or are required to die in a secure setting. The Prison Reform Trust revealed remarkable statistics that only approximately 10 prisoners per year are released from prison to die in the community either in their homes or in a hospice.

The RCGP Secure Environments Group and clinicians who work in secure settings from across the UK call on the Ministry of Justice to review the strict criteria which mean that only a tiny number of prisoners who are at the very end stage of their lives are allowed early compassionate release or release on temporary licence to die in the community. There are many cases where prisoners are clearly only days or weeks away from an expected death yet they are forced to die in prisons.

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The future NHS: time for another change?

How I agree with Roger Jones' insightful editorial.¹ The NHS has experienced an artificial (but nonetheless increasing) divide between primary and secondary care for nearly a quarter of a century now. A parlance has evolved which incorporates concepts such as 'spend' 'provider' and 'activity'. It is regrettable that a whole

generation of young medical and nursing staff don't know any different.

Prior to leaving general practice a year ago I crossed the primary/secondary care divide for 1 day a week working as a GP with special interest in acute medicine. It was soon apparent that not only did staff in emergency departments speak negatively about 'the GP' or 'the community' but neither had they the slightest idea what went on outside their establishment. Surprisingly perhaps the converse was also true: hospital practice has changed out of all proportion since many of us were juniors.

I still believe that being a GP is a wonderful career and things can only go upwards. However it is no coincidence that the most common question I was asked by junior hospital doctor colleagues and those that I trained was how to become a GPwSI in acute medicine.

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Delays in diagnosis of young females with symptomatic cervical cancer in England

Thank you for an interesting article which highlights the role of cervical visualisation in the timely diagnosis of cervical cancer and suggests that some GPs may forego pelvic examination (PE) despite the presence of abnormal vaginal bleeding.¹ A male medical student who had just completed his primary care attachment told me that during a supervised surgery, a patient presented with a gynaecological condition. As he was unable to do the required PE he advised the patient that the supervising female GP would do it instead. The GP responded by stating that

no PE was required as the patient would be referred to secondary care regardless of whether an examination took place or not.

I cannot think of any other body system that a GP would not examine prior to referral. Pelvic examination is more difficult than placing a stethoscope on a patient's chest in terms of time, chaperone requirements, issues of embarrassment for patients, etc, but I find it difficult to accept that the way to deal with these difficulties is to not do it. The history provides the majority of referral information but examination is vitally important in how we determine the nature of referral, routine or urgent, and how it is triaged in secondary care.

The evidence base for PE in primary care is limited, but what we do know is that performing PE does reduce the diagnostic interval in those diagnosed with a gynaecological cancer. Until we have a complete understanding of the role of PE in primary care, it must continue to be an integral component of our practice.

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Vision loss as a presenting symptom of type 2 diabetes mellitus

We read the article on sight-threatening diabetic eye disease with interest,¹ and would like to report an unusual case of undiagnosed type 2 diabetes mellitus presenting as visual loss. A 41-year-old male kennel owner presented with a 2-day

history of decreased vision and bilateral floaters. Visual acuity was 6/18-2 in the left eye and 6/60 in the right. Dilated fundus examination showed bilateral vitreous haemorrhages, with neovascularisation at the disc and elsewhere, and tractional retinal detachments. Non-fasting pinprick blood glucose was 20.3 mmol/L and blood pressure was 140/100 mmHg.

The patient denied weight loss (BMI 18 kg/m²) or polydipsia, although detailed questioning revealed a 20-year history of approximately 5 litres of fluid intake daily, predominantly sugary drinks. Three years before, he experienced slurred speech and pins and needles in his right arm, which was attributed to a viral infection and no investigations were done.

He was diagnosed with type 2 diabetes mellitus (negative anti-GAD antibodies and anti-IA-2 antibodies). Oral hypoglycaemics were commenced. He underwent urgent bilateral pan-retinal photocoagulation, then sequential vitrectomies with membrane dissection, endolaser, and gas tamponade. Visual acuity at the last clinic visit was 6/9 in the left and 6/36 in the right, attributable to diabetic macular oedema.

This unusual case highlights the importance of investigating neurovascular signs and symptoms, to include blood glucose measurement, as diabetes is increasingly seen in young working-age patients who neither report their longstanding diabetic symptoms nor conform to the 'metabolic syndrome'. The potential morbidity and mortality impact of undiagnosed diabetes underscores the importance of campaigns focusing on improving patient awareness of diabetic symptoms.

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Patient consent

The patient has consented to publication of this letter.

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Non-contact infrared thermometers

I wrote a letter to the *BMJ* last year setting out the evidence for non-contact infrared thermometry in adults.¹ Unlike paediatric use,² my conclusion was that these devices are not reliable in adults, largely because vasoconstriction of the blood supply to their foreheads and perspiration leading to a dangerously high false negative rate. A similar conclusion has been reached by the Scottish Health Technology Group, advising against their use for adults in Scottish NHS hospitals.³

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Headaches in the absence of other signs do not require imaging by GPs

Taylor *et al* provide an interesting review on the timeless conundrum of headaches and brain tumours.¹ Among the discussion they seem to advocate easier access to brain imaging in primary care. This is a shame, especially since the question was answered by a well-written study (by two of the same authors) in the *BJGP* 7 years ago.² I use that paper to teach medical students and GP trainees that the positive predictive value of a headache, for a brain tumour, is 0.09%. (In other words, if you have a headache there's only a 0.09% chance of it being a brain tumour). A new onset seizure, on the

other hand, has a PPV of 1.2% for a brain tumour. The problem with imaging people's brains 'just to make sure' is, as the authors rightly point out, an incidental finding. A well carried out study showed 0.47% of healthy young men have an intracranial tumour,³ which is slightly more than the positive predictive value of a headache anyway. Taylor *et al* also, erroneously, remark 'the commonest symptom' of a brain tumour is headache, but in fact only 10% of people with a brain tumour ever report a headache before the diagnosis. Easier access to brain imaging for GPs will only mean one thing: more brain scans. And more brain scans means only one thing: more incidental findings.

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Competing interests

The author missed a brain tumour 3 years ago in a young woman presenting with headaches (the patient is now well). He has seen a similar patient have a meningioma, erroneously attributed to the patient's headaches, resected; the headaches persisted despite the surgery and abated once the patient's emotional state had improved.

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Family and Friends Test

The NHS Family and Friends Test (FFT) will be implemented into general practice in December 2014¹ and The NHS Strategic Projects Team is supporting this implementation across the Midlands and East region.

In our workshops, GPs and managers initially considered FFT another mechanism for complaints' generation; but training has demonstrated that FFT can promote a better relationship between