Clinical Practice Research Datalink (CPRD, formerly the GPRD) record information on issued prescriptions, prescribing analyses and cost (PACT) data records prescriptions that are dispensed. Neither of these methods will record the proportion of prescriptions that are actually taken by the patient and we are unaware of any research studies that have specifically addressed this important question. GPs can record delayed prescriptions using the Vision software system, but it is unclear how frequently this Read Code is used.

However, estimates suggest 80–90% of antimicrobials are prescribed in the community so even if we are overestimating antibiotic use, it is clear that the majority of antimicrobials are prescribed and dispensed in primary care. Research studies based on both issued and dispensed prescriptions using different populations all deliver the same message: there is major heterogeneity in prescribing, and this offers scope to reduce antibiotic use.^{2–4}

There is a clear need for better surveillance data on antimicrobial prescribing and resistance in hospitals and in primary care and this is the rationale behind the English Surveillance Programme for Antimicrobial Utilization and Resistance (ESPAUR).⁵ Optimising antibiotic use is a fundamental part of the response to antimicrobial resistance. This will only be achieved by changing patient and clinician behaviour in the community and in hospitals.

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End-of-life priorities in practice

Following criticism of the Liverpool Care Pathway (LCP) in an independent review in 2013, it was recommended that it be phased out.¹

The Leadership Alliance for the Care of Dying People published a response to that review in June 2014.² This listed five priorities for care, broadly addressing the importance of an individual, holistic approach, with emphasis on communication, listening to the patient, and recognition of impending death.

In general practice, end-of-life care is delivered in the patient's home, which may be unfamiliar to the doctor, especially out of hours. Time pressure can inevitably increase the stress.

With this in mind, I set out to create a checklist for what GPs actually need to do during the consultation. We often talk about giving the patient TLC, but what does that mean? In this case, it stands for Tailor made, individual care; Listening; and good Communication.

My checklist applies the basic principles of care, but in a structured and practical way. It enables all people involved with the patient, be that a GP, nurse, or carer, to remember the needs of the dying patient and take practical steps to address them, or to ask a clinician to address them:

1. Is the patient dying in their chosen place of death, if possible?
2. Is the patient in pain? Is analgesia prescribed, and is it available today?
3. Is the patient feeling sick or vomiting? Is medication prescribed and available to help with this?

4. Is the patient agitated? Is medication prescribed and available to help with this?
5. Have unwanted medications been stopped?
6. Has a Do Not Resuscitate order been signed, and if so is it available?
7. Is the patient thirsty? Does their mouth need care?
8. Are their bladder and bowels comfortable?
9. Has somebody spoken to the family or other loved ones today?
10. Are there any other concerns which have not been addressed?

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Basal cell carcinomas: a growing problem

Over the past number of years there has been a significant rise in the number of referrals regarding sun damaged skin lesions, more specifically basal cell carcinomas, in the head and neck region, to our maxillofacial department for surgical management.

Admirably, our colleagues in primary care are ever vigilant, with the majority of basal cell carcinomas being fortuitously detected at check-up examinations.

The well documented aetiology which includes genetic predisposition and ultraviolet radiation exposure,¹ is of particular relevance in our western population given the fair type 1 and type 2 skin makeup and increased feasibility of travel to hotter climates.² The shift in