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

population age is a significant contributory factor also, given the accumulative nature of the skin damage.³

Despite the publicity effort regarding UV sun protection it is likely we will see some semblance of decrease only after knowledge and display of the detrimental effects are openly shared and debated in society. Unfortunately the trend related to sun damaged skin lesions is set to continue.

Perhaps a new wave of deterrence such as was taken in the anti-tobacco campaign should be a priority for the health service. The implementation of a universal ultraviolet light prevention programme in places of work and education would create the opportunity to reduce the incidence of morbidity associated with this preventable disease.

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STI testing in emergency contraceptive consultations

We recently read the Faculty of Sexual and Reproductive Healthcare (FSRH) Clinical Guidance (2012) that recommends 100% of women attending for emergency contraceptive have a discussion regarding future contraception, and are offered the opportunity for sexually transmitted infection (STI) testing, including HIV.¹ The FSRH recommends STI testing

Table 1. Number of women being offered future contraceptive advice and STI testing

	Offered	Not offered	Total
Future contraceptive	31	3	34
STI testing	8	26	34
Total	39	29	68

The Fisher's exact test shows that the two-tailed P value is <0.0001, indicating significant difference between the proportions of women being offered future contraceptive advice and STI testing.

because studies showed up to 9.1% of women aged <25 years presenting for emergency contraceptive had *Chlamydia trachomatis*.^{2,3} The Quality of Outcomes Framework (QOF) also recommends that 50–90% of women receiving emergency hormonal contraception are offered information about long-acting reversible methods of contraception.⁴ However, QOF does not mention about STI testing.

We conducted an audit in our general practice investigating whether women attending for emergency contraception were offered STI testing and information regarding future contraception. From November 2012 to November 2014, we identified 34 consultations in which women were given levonorgestrel, ulipristal, or copper coil for emergency contraception. Future contraception advice was given in 31 (91%) of the consultations, but STI testing was offered in only eight (24%) of them (Table 1). Only five of the eight patients accepted the STI testing, but were all tested for *Chlamydia* only.

The 24% of women being offered STI testing in our general practice was much lower than the 71% of women being offered STI testing in a genitourinary medicine clinic in Edinburgh.⁵ The low proportion in our study may be due to STI testing not being monitored by QOF. In contrast, while being monitored by QOF, the proportion of women being offered future contraceptive advice was significantly higher than that of STI testing. Our study was limited by the low number of women attending for emergency contraceptives in our practice. To validate our findings, we encourage other general practices to conduct similar studies to investigate the proportion of women attending for emergency contraceptive being offered STI testing. Furthermore, we would like to ask the Royal College of General Practitioners to raise awareness of offering STI testing to women presenting for emergency contraception. Finally, we would like to ask QOF to consider adding STI testing in its monitoring parameters.

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Virtually addicted

This is a very important subject and I do wish to 'land' it on Planet Trivia, yet there are others besides children who are also dependent on their screens and to be honest, I read the article title¹ as applying to many GPs in the UK. Many of the public, including myself, are really fortunate to be registered with many an excellent and caring GP and there