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.

Mervyn Huston,

Department of Oral and Maxillofacial Surgery, Musgrove Park Hospital Taunton, Taunton and Somerset NHS Foundation Trust, Taunton.

E-mail: hustonm@tcd.ie

REFERENCES

1. Gailani MR, Leffell DJ, Ziegler A, *et al.* Relationship between sunlight exposure and a key genetic alteration in basal cell carcinoma. *J Natl Cancer Inst* 1996; **88**: 349–354.
2. Zak-Prelich M, Narbutt J, Sysa-Jedrzejowska A. Environmental risk factors predisposing to the development of basal cell carcinoma. *Dermatol Surg* 2004; **30**: 248–252.
3. Diffey BL, Langtry JA. Skin cancer incidence and the ageing population. *Br J Dermatol* 2005; **153**: 679–680.

DOI: 10.3399/bjgp15X683437

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.

Eugene YH Yeung, Eleanor Comben, Charlotte McGarry and Rebecca Warrington,

College of Medical and Dental Sciences, University of Birmingham, Birmingham and Lion Health Medical Centre, Stourbridge.

E-mail: eugeneyh@gmail.com

REFERENCES

1. Faculty of Sexual & Reproductive Healthcare. Emergency Contraception. 2012. <http://www.fsrh.org/pdfs/CEUguidanceEmergencyContraception11.pdf> (accessed 7 Jan 2015).
2. Kettle H, Cay S, Brown A, Glasier A. Screening for *Chlamydia trachomatis* infection is indicated for women under 30 using emergency contraception. *Contraception* 2002; **66**(4): 251–253.
3. Brabin L, Thomas G, Hopkins M, *et al.* Delivery of chlamydia screening to young women requesting emergency hormonal contraception at pharmacies in Manchester, UK: a prospective study. *BMC Womens Health* 2009; **9**: 7.
4. Health & Social Care Information Centre. 2014/15 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF) guidance for GMS contract 2014/15. NHS England Gateway reference: 01264. March 2014. http://www.hscic.gov.uk/media/14019/QOF-Guidance-GMS-Contract-2014-15/pdf/QOF_guidance_GMS_contract_2014_15.pdf (accessed 7 Jan 2015).
5. Goodall L. Emergency contraception prescribing in a GUM clinic: missed opportunities for improving sexual and reproductive health. *J Fam Plann Reprod Health Care* 2012; **38**(2): 140.

DOI: 10.3399/bjgp15X683449

Virtually addicted

This is a very important subject and I do not 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

is a technology in the consultation room that perhaps we are increasingly in danger of abandoning, namely the billions of mirror neurones that rely on visual information to generate empathy and rapport with patients. Every glance away at a computer screen or worse, being serially embedded in it, for reasons of QOF, personal acopia, or lost or never-present skills, represents the placement of this required and increasingly essential human brain-derived technology in front of those that have derived from the human brain — once described as the 'most complex mechanism in the known universe'.

And why, anyway, in this day and age do we not have Head-Up Touch-sensitive Displays (perhaps they could be called Eye-Pads?) being used routinely in healthcare settings, together with abandonment of the 1868 QWERTY keyboard and 1946 mouse?

As Einstein said:

'The intuitive mind is a sacred gift and the rational mind is a faithful servant. We have created a society that honors the servant and has forgotten the gift.'

In this context, I would say that it is time to 're-mind' the rational mind that it and all its derivatives are respected for their servitude, while being kept firmly in their place.

Chris Manning,

*Convenor, NHW Wellbeing Action Network
UPstream Healthcare Ltd.*

E-mail:

chris.manning@upstreamhealthcare.org

REFERENCE

1. Sigman A. Virtually addicted: why general practice must now confront screen dependency. *Br J Gen Pract* 2014; **64(629)**: 610–611.

DOI: 10.3399/bjgp15X683461

Correction

In the November 2011 article by Hippisley-Cox J, Coupland C. Identifying patients with suspected lung cancer in primary care: derivation and validation of an algorithm. *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X606627, the Results section showed two incorrect numbers. In the second paragraph it states 'A total of 1 243 329 patients'; this should have been 'A total of 1 342 329 patients'. It also states '... 1 342 329 patients for analysis.'; this should have been '... 1 267 151 patients for analysis'. The errors have no effect on any of the results or conclusions. The corrected version will be published online.

DOI: 10.3399/bjgp15X683473