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Clinical signs in elbow pain

Javed *et al's* guide to the management of elbow pain¹ is disappointing on several fronts including its support for the myth that only tennis players get tennis elbow,² but especially in its description of the clinical signs of this condition and golfer's elbow.

The essence of examining a joint is to distinguish between conditions of the joint proper and those of the muscle and tendons that move it. 'Active' and 'passive' movements do not achieve this because both move the joint. It is necessary to test isometric resisted movement to separate these possibilities. If resisted movement is painful, it must be the muscle/tendon being stretched that is the source of the pain (because the joint itself is not moving). Thus tennis elbow produces pain on resisted supination, especially when trying to extend the wrist as well. This is because the lateral epicondyle is the origin of the common supinator muscles that extend and supinate the wrist. Similarly, pain on resisted pronation and wrist flexion is characteristic of golfer's elbow.

The authors do mention the wrist, but could perhaps have given more emphasis to the fact that patients with carpal tunnel syndrome often complain of pain that extends up to the elbow and beyond.

Finally the authors' advice for work-related problems is dismissive, especially in the context of a problem that affects the patient's livelihood. Problems with workstation geometry are common and can often be helped by an occupational therapist or even by the simple expedient of changing mouse hand for a while.

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Give us a reason to be a GP

It's the big elephant in the room. As doctors in training the often ambivalent to downright contemptuous responses from some hospital specialists and colleagues when one expresses an interest in general practice does little to inspire confidence that it is a good career move. Surely this attitude has got to be challenged? Due to negative media portrayals and a lack of understanding of what general practice involves and contributes to patient care, juniors in foundation training and medical students are often left with a list of reasons not to be a GP.

Although changes are required, they will not happen overnight and certainly not in time for the next recruitment cycle, but is it not time to start confidently highlighting the many positive aspects of being a GP so they are made more widely known?

For instance, as raised by Lyon-Maris *et al's* informants, portfolio roles have the potential to make being a GP very attractive.¹ There are countless examples of GPs pursuing such portfolio careers.^{2,3} Unfortunately, not many colleagues know what a portfolio GP is. They aren't aware GPs can combine routine clinical work with doing just about anything, be it specialising in a specific clinical area to non-clinical work such as academic research or expedition medicine, to working in the media, to management roles, to working as a medical reservist within the armed forces. The list is limitless with the flexibility and control of being able to develop your career to suit your interests and needs as they change over time. Many medical students and foundation doctors have already developed interests in these areas, and by showing them that being a GP will allow them to combine this into a regular part of their working week could result in an improvement in application rates. Furthermore, GPs with such additional roles can translate these skills to innovate and improve primary care, as well as making them more resilient against the pressures of clinical work.

So how about we start promoting the endless possibilities of a career in general practice, especially to those who are yet to choose their specialty?

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The diagnostic accuracy of faecal calprotectin in investigations for suspected inflammatory bowel disease in children

Thank you for providing guidance for adults with suspected inflammatory bowel disease (IBD).¹ Unfortunately paediatric gastroenterologists receive more referrals to endoscope children on the basis of a 'positive' faecal calprotectin test based on the false interpretation of a cut-off of 50 µg/g faeces as a surrogate for IBD in children. However, the meta-analysis clearly illustrates an important age-dependent difference of applying the test in children (0–16 years). Although the sensitivity of the