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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

test is comparable, the specificity of the test in children is only 76% compared with 96% in adults.² In a retrospective analysis of 190 children, faecal calprotectin was positive (above 50 ng/g faeces) in 91 children of the control group with IBS, non-specific colitis, post-infectious enteropathy, cows' milk/wheat intolerance, pinworms/enterobius, allergic enteropathy, food allergies, worms, coeliac disease, miscellaneous, or no pathology identified, with a median of 65 µg/g faeces in the non-IBD control group (range 20–235).³ To achieve a comparable specificity of 95% the sensitivity would decrease to 73% with a cut-off for the test as great as 800 µg/g faeces.

We welcome very much all efforts to diagnose IBD much earlier in children. As practical advice, we recommend the referral of children with results >50 mg/g to a paediatrician, and certainly with results of >800 ng/g, or all children with a high clinical suspicion of IBD directly to a paediatric gastroenterologist.

To enable a rapid assessment of children with red-flag signs, the GP's thoroughness in providing all necessary clinical information (symptoms, growth/height/percentiles and documented changes, stool frequency, consistency, blood in stool), family history, and blood test results (full blood count, C-reactive protein, erythrocyte sedimentation rate, albumin, urea + electrolytes, tissue transglutaminase with immunoglobulin A levels) is essential for prioritisation and eligibility for endoscopy. To avoid unnecessary endoscopies or inadequate prioritisation, these data need to be communicated widely to GP teams.

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The FGM enhanced dataset: how are we going to discuss this with our patients?

In October 2015, the female genital mutilation (FGM) enhanced dataset begins collecting data from GP surgeries about women who have experienced FGM. Reading the information sent to my GP surgery about this dataset,¹ the correspondence in the *BMJ*,² the *BJGP*,^{3,4} and online,⁵ I am concerned about the requirement to submit personal information about my patients without their consent, and managing my fair processing requirements.

Mostly though I find myself wondering how this conversation will be experienced on the clinical front line.

For many of the women I see in my GP surgery, when I ask about whether they have experienced FGM (been 'cut' down there, or closed), it may be the first time they have spoken about it to a doctor. I am mindful that I need to be aware of the possible psychological and physical sequelae of FGM, including pain, depression, and PTSD. Furthermore, I am aware that many have had complex, often harrowing journeys to the UK. I aim to establish a trusting patient-doctor relationship, before embarking on this conversation.

The Bristol PEER study found that 'from the discussions with the women, it was clear that confidence and trust in the health services was minimal'⁶ and that 'most of them felt discomfort in confiding in their doctors especially on such a sensitive issue such as FGM'.⁶ When, during this sensitive and difficult process, do I mention the dataset? Before I ask her to describe an event that has usually impacted hugely on her throughout her life, from childhood to adulthood, marriage to motherhood? Or do I wait until she tells her story, then thank her and inform her that I now need to talk about informing HSCIC? Can I put myself in her shoes and try to imagine this conversation? What might it mean for her? And how will I feel as a health professional having to discuss this?

It seems inevitable to me that clinicians and women will respond to this government requirement by neither asking nor telling, so avoiding a difficult situation. However, this would counter the efforts made to encourage FGM disclosure, and reduce the opportunities to offer support to women or

safeguard their children.

We must reflect on the conversations we will need to have: will this help tackle FGM?

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Conflict of interest

GP member of Oxfordshire FGM operations group/ GP lead for FGM. Co-recipient of a small grant undertaking a pilot project in co-designing research into experiences of FGM.

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Meetings between experts

I greatly enjoyed Dr Snelson's piece and would like to share my experiences as GP tutor in Central Manchester.

We called our GP education sessions 'meetings between experts' to emphasise that GPs are specialists and experts too.