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Editor's choice

Keep examining patients

I would heartily endorse Rose Brettell's¹ and Crispin Fisher's² view that careful physical examination of patients should be paramount and particularly in the isolated setting of the GP's consulting room far away from pathology labs and 'hi-tech' investigative machines.

But I feel one reason has not been sufficiently emphasised. Patients expect to be examined, respect it, and are reassured by it. When the doctor lays his hands on the areas of the body whose symptoms suggest are diseased the doctor builds a tactile bridge to the patient with which no amount of talking can equate. My grandson, following years of suffering severe childhood eczema, travelled over 200 miles to see a consultant dermatologist who never even looked at his skin!

I have friends with chronic back pain who have never had their backs examined! Keith Hodgkin, a distinguished GP guru of the sixties and seventies, maintained that, *'Once you've done a rectal examination the patient will tell you everything!'*

Perhaps two kinds of doctors are emerging: the 'hi-tech' doctor in the hospital who uses machines to diagnose and the GP in their consulting room who uses their five senses plus a few simple instruments to achieve the same end — and incidentally much more quickly and certainly less expensively.

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Hearing crackles: why all GPs should pass PACES

Crispin Fisher's enjoyable letter¹ brought to mind an experience I had as a teaching GP on a cold morning's surgery.

First of all I saw a male in his 50s with flu-like symptoms and high temperature. Auscultation of his chest disclosed bilateral crepitations in most areas. I let my trainee and student listen to his chest. I decided he needed to go to hospital. While waiting for the admissions officer at the local hospital, the three of us discussed possible diagnoses and management. The patient was duly admitted. I was very satisfied, especially having been observed by a trainee and medical student. Later that morning I saw a patient in his 30s with a cough. To my surprise he also had crepitations on the base of one side only. He was a smoker. I sent him for a chest X-ray at the local chest clinic.

Later that day, I phoned the hospital to check on my patient. The registrar told me the patient had only a minor chest infection. The X-ray was clear and he had been sent home with antibiotics. I then phoned the chest clinic and found that the second patient's X-ray was also clear. I was very surprised. Fortunately, neither the trainee nor medical student was with me, so I escaped embarrassment. I wondered what might have gone wrong. A careful examination of my stethoscope revealed a hairline crack on the plastic tube on the right side, just below the attachment with the metal. This crack became wider when I moved the stethoscope from side to side, but did not open much in the upright hanging position. I never used it again. It is still with me as a piece in my personal museum. I revealed the truth to my trainee and the medical student the following day and they both saw the funny side. We are, after all, only human.

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Response to a news article on the RCGP website

I have read with great interest both the news article published on the RCGP website, 'Thousands of GP appointments "lost" due to children with conjunctivitis being turned away from nursery, says RCGP',¹ and the leaflet produced by the RCGP to educate childcare professionals, parents, and teachers about managing conjunctivitis in young children.² General practice is under unprecedented workload pressure,³ and every attempt to rationalise appointments so that resources can be utilised appropriately ought to be commended.

The purpose of the aforementioned leaflet is to reassure parents *et al* that young children with conjunctivitis do not require assessment by a GP, nor exclusion from school. I wonder, however, that in emphasising this message, if the RCGP has oversimplified the advice regarding the use of antibiotics. The leaflet states that children 'DON'T need to ... use antibiotics'. A literal interpretation of this particular language by parents *et al* may lead to children with severe conjunctivitis not receiving treatment and risking serious complications. This advice is not in keeping with a National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summary (CKS),⁴ which, having based its recommendations on a recent Cochrane Database Systematic Review,⁵ concludes that topical antibiotic treatment should be administered in severe cases.

The NICE CKS accepts that there is no agreed definition of severe conjunctivitis, and that it is reasonable to use clinical experience to determine the severity of a case. Perhaps a revised version of the leaflet, one that applies specialist ophthalmology input to highlight the difference between