

glaring elephant in the room for the future screening of lung cancer or other smoking-related diseases.

Nigel J Masters,

Retired GP and GP Administrator, Highfield Surgery, Hazlemere, High Wycombe.  
Email: [mastersnigel@gmail.com](mailto:mastersnigel@gmail.com)

### Competing interests

The author with his practice nurse created the smoking pack year calculator to simplify pack year recording (<https://www.smokingpackyears.com>).

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## Relative frequencies of ophthalmia neonatorum and congenital nasolacrimal duct obstruction

I appreciate the useful article from Maqsood and Mahmood on the identification and diagnosis of herpes simplex ophthalmia neonatorum.<sup>1</sup> As McKechnie and Snelson suggest in their response, a key differential for 'sticky eye' in the neonate is congenital nasolacrimal duct obstruction.<sup>2</sup>

A large cohort study of all children in Olmsted County, Minnesota, found that the prevalence of congenital nasolacrimal duct obstruction was 11.3%. Of these cases, over 90% were identified in primary care.<sup>3</sup>

Ophthalmia neonatorum however is comparatively rare. A survey sent to members of the American Association for Paediatric Ophthalmology and Strabismus found that most ophthalmologists encountered fewer than five cases per year. Of these cases, the most common causative organism was *Chlamydia trachomatis*.<sup>4</sup>

The diagnostic challenge for the GP is clear. While they will see numerous cases of congenital nasolacrimal duct obstruction, they will rarely encounter ophthalmia neonatorum. From the literature it appears that herpes simplex ophthalmia neonatorum is relatively uncommon even for specialists working in a more selected population.

Given this difficulty, the pragmatic

approach of referral of all cases suspicious for infection, as suggested by McKechnie and Snelson, is prudent. Prompt secondary care assessment would then allow timely and effective treatment to prevent sight-threatening complications.

Thomas Weatherby,

Foundation Doctor, North West Anglia NHS Foundation Trust.  
Email: [tw418@cam.ac.uk](mailto:tw418@cam.ac.uk)

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## Gear change: supporting and encouraging cycling on prescription

I read with great interest the paper written by Heather Jones, which presents the need of 'cycling on prescription' to begin within the walls of the NHS in order to influence and benefit the wider population.<sup>1</sup>

As a fourth-year medical student in London, I am continuously travelling to different hospitals and GP practices across the city, mainly by bicycle. Through my own experience, I must agree with Heather Jones that the provision of cycle amenities at many of these NHS sites is poor. This poor infrastructure, such as limited (if any) access to safe bicycle storage and onsite showers, frequently deters me from cycling to these locations. Evidence shows that lack of safe parking is a major barrier to both cyclists and non-cyclists; conversely, non-cyclists state they will feel more enabled to begin cycling if further allocation of bike racks were placed at health centres.<sup>2</sup>

Poor local cycling conditions may make clinicians wary to prescribe cycling. However, the 'focused effort to promote cycling'<sup>1</sup> to NHS staff may fail to empower the wider population simply because it does not remedy the largest deterrent to cycling, which is fear of injury to oneself.<sup>2</sup> One of the main themes of the UK Government's Gear Change policy is to enable and protect people when they cycle.<sup>3</sup> Proposed Gear Change infrastructure interventions include the development of segregated cycle lanes, which have been proven to reduce the likelihood of cyclist injuries, while simultaneously producing a 'safety in numbers' phenomena.<sup>4</sup> The Gear Change policy thus has the framework to remedy this large deterrent to cycling, thus hopefully increasing the adherence rate in those who are socially prescribed cycling.

While it can be argued that promoting NHS staff to cycle will increase local cycling conditions, Gear Change aims to improve cycling infrastructure and promote cycling to the UK population as a whole. Through further offers of patient cycle training to mediate patient risk, peer support groups, and loaning of cycles, cycling on prescription may be ushered in as a staple in social prescribing.

Timothy E Yeo,

Fourth-Year Medical Student, Barts and the London School of Medicine and Dentistry.  
Email: [t.yeo@smd16.qmul.ac.uk](mailto:t.yeo@smd16.qmul.ac.uk)

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