

All letters are subject to editing and may be shortened. General letters can be sent to bjgpdisc@rcgp.org.uk (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication. For submission instructions visit: bjgp.org/letters

An earlier diagnosis of heart failure

Thank you for this important editorial, but I fear it may add fuel to GP bashing. The dataset (reference 2) is dated 2010 to 2013 and I would hope (without direct evidence but from previously working as a GPwSI in cardiology) that things have changed radically in the past 9 years. Reference 7, cited for no improvement in mortality, plays down that only 7.2% of those dying had heart failure as the cause of death and that there was an improvement over the time, albeit not large, but there was no comparison in the reference to controls of the same age.

My main reason for writing is that we are de-skilling the normal GP in managing a common illness. If the guidelines empowered a GP to manage this with easy access to an echo (not forgetting initial clinical examination, ECG, and symptom treatment with diuretics) and the echo report had useful advice rather than numerical values, perhaps regular updated training to take priority over safeguarding 'updates' would save many more lives and improve job satisfaction.

John Sharvill,
Part-time GP, NHS.
Email: john.sharvill@nhs.net

REFERENCE

1. Taylor CJ. Earlier heart failure diagnosis in primary care. *Br J Gen Pract* 2023; DOI: <https://doi.org/10.3399/bjgp23X731481>.

DOI: <https://doi.org/10.3399/bjgp23X731793>

Author response

Thank you Dr Shavill for reading my editorial.¹ As a practising GP, I appreciate how difficult heart failure diagnosis can be, particularly in the presence of multimorbidity, and I was very mindful of the intense pressures on general practice when writing the piece.

Reference 2 is widely cited given the novel findings and our more recent work confirms patients are still frequently

admitted to hospital at the time of heart failure diagnosis and have worse outcomes. Reference 7 is our survival analysis of over 55 000 people with heart failure published in the *BMJ*. Almost half of patients had heart failure as a contributory factor on their death certificate, and the Kaplan-Meier curve in Figure 5 of the article shows the significant differences in mortality: people with heart failure were three times more likely to die than comparators of the same age and sex (hazard ratio 3.36 [95% CI = 3.31 to 3.42]).

The National Institute for Health and Care Excellence (NICE) chronic heart failure guideline recommends natriuretic peptide testing for patients presenting with symptoms suggestive of heart failure to guide referral decisions, but I agree that there can then be a significant wait for echocardiography and the reports are often complex. NICE recommends that a diagnosis of heart failure is made by a specialist. I agree that accessible training in a variety of formats for the busy GP could help to raise awareness of the opportunities for earlier heart failure diagnosis.

Clare J Taylor,
Academic GP, University of Oxford.
clare.taylor@phc.ox.ac.uk

Competing interests

Clare J Taylor received personal fees from Roche outside the submitted work.

REFERENCE

1. Taylor CJ. Earlier heart failure diagnosis in primary care. *Br J Gen Pract* 2023; DOI: <https://doi.org/10.3399/bjgp23X731481>.

DOI: <https://doi.org/10.3399/bjgp23X731829>

Group A strep: has point-of-care testing for primary care finally come of age?

The recent outbreak of group A streptococcal infections in the UK¹ highlights the need for accurate and prompt

diagnosis of throat infections; a positive diagnosis results in at least 24 hours off work or school for patients (and their caregivers), antibiotic prescriptions for the patient and vulnerable contacts, and inevitable concern among wider contacts. This problem has been exacerbated by shortages of antibiotics. Point-of-care tests are now available that have sensitivity and specificity >90%,² with potential to significantly improve clinical diagnosis and reduce unnecessary antibiotic prescriptions. We used the Abbott ID Now point-of-care testing system to test patients with a Centor score³ of 2 or 3, who might have received an immediate or deferred prescription: 43% of patients in this group tested negative, and therefore were not treated with antibiotics.

Although the unit cost of each test is around £20 +VAT, the wider system savings in reduced time off work or school, reduced pressure on pharmacies and antibiotic supplies, and reduced number of patients re-presenting to primary or urgent care settings should prompt discussion of the use of point-of-care testing in the proposed respiratory hubs and in routine primary care.

Rob Daniels,
GP, Townsend House Medical Centre,
Seaton, Devon.
rob.daniels@nhs.net

Competing interests

Rob Daniels works in an ENT clinic that took part in a trial of COVID-19 testing using Abbott ID Now technology, but was not paid for his part in this trial. At the beginning of the group A streptococcal pandemic his PCN received 48 free tests to try.

REFERENCES

1. Wise J. Strep A: GPs are put on alert as cases and deaths rise. *BMJ* 2022; **379**: o2941. <https://www.bmj.com/content/379/bmj.o2941> (accessed 13 Jan 2023).
2. ID NOW™ strep A2. ID NOW STREP A2. Abbott. <https://www.globalpointofcare.abbott/en/product-details/id-now-strep-a-2.html> (accessed 13 Jan 2023).
3. Kim NN, Marikar D. Antibiotic prescribing for upper respiratory tract infections: NICE guidelines. *Arch Dis Child Educ Pract Ed* 2020; **105**(2): 104-106.

DOI: <https://doi.org/10.3399/bjgp23X731805>