Correspondence

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Diagnosis of acute otitis media in primary care

We read with interest Blomgren’s article suggesting that GPs over-diagnose otitis media compared with a single ENT physician using specialized equipment.1 Before taking this result at face value, we feel that a number of important issues need to be addressed. The first is a lack of an adequate reference standard in this work. As stated by the authors themselves, definitive diagnosis of otitis media is not possible without examination of middle ear secretions. Without this invasive investigation, it is difficult to unravel the precise cause of the discrepancies in diagnosis recorded. We suggest that at least part of the variation in diagnosis might be explained by variation in the spectrum of disease seen in primary care as compared with hospital practice.2 Secondly, although the use of specialist tools such as tympanometry may improve diagnosis, simple signs and symptoms such as ear pain and colour of the tympanic membrane have respectable diagnostic performance.3 Thirdly, in comparing like with like, the time taken in assessing each patient is important (at least it is when you have a full waiting room expecting to see you). Do the authors have any data on this? Finally and perhaps most importantly, were the management strategies arising from these cases compared? Many cases of milder otitis media can be treated safely with simple analgesia and without the use of antibiotics.4

What difference in practical terms would the variation in diagnostic labels have made?

Yours faithfully
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References

Managing acute cystitis in women

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We thank Anders Baerheim for his interest in our paper.1 We would like to address some of the points he raises.

There is still considerable uncertainty as to the prior probability of urinary tract infection (UTI) (-defined as a colony count of ≥10^5 colony-forming units (c.f.u.)/ml) in women consulting in primary care. Reported priors have ranged between 12 and 59%.2 The true prior is critically important, as positive likelihood ratios in our and more recent studies of individual symptoms and signs are no higher than 2.1,3,4 If single symptoms and signs are used as a diagnostic guide, post-test probabilities are not raised substantially, certainly not into the treatment range.5 For this reason, clinical practice guidelines recommend that combined symptoms and signs are assessed in each patient (which have more powerful diagnostic test properties to raise or lower the post-test probability of UTI) allied with the use of near patient dipstix tests if after taking a history and examining a patient, post-test probability of UTI is intermediate.7,4 We agree with this diagnostic strategy, acknowledging that this approach needs to be validated in randomized trials assessing its impact on prescribing practice and clinical outcome.

We agree that our ‘gold standards’ of ≥10^5 c.f.u./ml and re-consultation within 1 month are imperfect and clearly describe their limitations in the discussion section of our paper.1 Two different ‘gold standards’ were used
as a pragmatic means to assess alternative but related end points: laboratory diagnosis and clinical outcome.

Like others, we think empirical treatment on the basis of individual symptoms and signs exposes patients to unnecessary antibiotics. Attendant problems of medicalization, cost, contraceptive failure, side effects and antibiotic resistance are not trivial. There is good evidence that antibiotics are effective in reducing symptoms and duration of illness in women with UTI. Antibiotics should be prescribed to those patients with the highest probability of bacterial infection: clinical prediction rules incorporating symptoms, signs and (if necessary) near patient dipstix test results are the most rational way of achieving this aim.

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Screening for alcohol misuse

Aira et al.’s constructive paper identifies seven categories influencing the physician:patient dialogue for alcohol consumption. We recently have completed a study of Senior House Officer (SHO) attitudes to screening for alcohol misuse in Accident and Emergency (A&E) (127 SHOs over 5 years). Briefly, we compare the experiences of GPs and A&E staff under the headings identified.

Sensitive nature of alcohol drinking
It is likely to be more problematic for GPs to broach the subject of alcohol as they are community rather than hospital based. A&E practitioners are less likely to meet their patients socially. Both types of doctor are equally likely to collude with the patient in terms of their own culturally engrained attitude to alcohol use/misuse—insight is the key.

Reason for consultation
Aira et al. comment “None of the physicians was ready to ask about alcohol consumption routinely in every consultation, but only when the reason is connected to alcohol.” We have identified a list of presenting complaints (‘the top 10’) which mandate the recording of an alcohol history using the Paddington Alcohol Test (PAT), which takes <1 min to administer. Over 60% of all A&E attendees have a presenting complaint from the ‘top 10’. We educate our practitioners to respond to the patient’s agenda first before introducing our own agenda of possible alcohol misuse. Further, in order to make it appear the natural course of the consultation, we teach our practitioners to introduce the subject non-judgementally by saying, ‘we routinely ask all patients who have had a fall (or whichever presenting complaint is relevant) do you drink alcohol?’ We emphasize the importance of detecting alcohol misuse at an early stage in a patient’s drinking history, when they may be more amenable to opportunistic intervention.

Awareness of patient’s alcohol problem
Prior knowledge concerning a patient’s alcohol problem is an advantage that primary care physicians have over A&E staff. We use the PAT routinely with repeat attenders, ‘repeat attendance’ being the 10th condition of the ‘top 10’.

Patient factor
GPs are inhibited from asking about alcohol consumption by value judgements concerning appearance, age, sex and profession. Alcohol is no respecter of such arbitrary divisions; doctors need education to gain insight.

Availability of intervention tools
Aira et al. describe the feelings of inadequacy that many GPs have with regard to managing early alcohol...