their general practitioner. Taking into consideration the points already made about possible reasons for their visit to the department and the general nature of the question asked, the figure does not seem to differ from that found in other studies.1

The study asked a vague general question about consultations with a general practitioner before the visit to the accident and emergency department and consequently got vague general data, from which no conclusions can be drawn. Perhaps more disturbing is the implied criticism of general practitioners’ diagnostic ability. I hope that I am being hypercritical after my second 120 hour week this month and that no such criticism was meant.

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“Barfly” injuries

EDITOR,—A new sport has joined the list of so-called safe activities. “Barfly” jumping entails dressing in a Velcro suit, leaping from a trampe and attempting to stick oneself against a Velcro wall (often upside down).

A 42 year old woman recently presented to the trauma service four days after becoming “unstuck” on the wall, while upside down, and sustaining a forced flexion injury of her neck. At presentation she complained of increasing pain in the lower part of the neck and paraesthesia of both arms. The lower cervical spine was tender on palpation, but there was no objective neurological deficit. Plain radiography and computed tomography showed an unstable compression injury of C6 and C7, with subluxation of both facet joints and fracture of the C6 spinous process. She was treated with halo traction to reduce the subluxation, and a successful posterior fusion of C6 and C7 was performed. She was discharged home on the seventh postoperative day.

When we contacted several large life insurance companies we found that if this patient had “wind up” doctors into admitting that it was unreasonable to assume that this occurred more commonly in one particular group of attenders in our study; thus its effect is unlikely to have altered our conclusions.

Interestingly, not all emergency admissions are appropriate, nor are they all admissions of seriously ill patients; in Nottingham, adults with a given complaint who have seen their general practitioner before they refer themselves to an accident and emergency department are just as likely to be admitted as other attenders; thus we caution against any scepticism that may be directed towards them in the casualty department. Though Michael Dixon reasonably suggests that patients can “wind up” doctors into admitting that it is unreasonable to assume that this occurred more commonly in one particular group of attenders in our study; thus its effect is unlikely to have altered our conclusions.

Inevitably, not all emergency admissions are appropriate, nor are they all admissions of seriously ill patients; in Nottingham, however, the decision to admit each patient lies ultimately with those attending the department, not, as R M Ridsdill Smith suggests, with a casualty officer who is playing safe. It is usually a senior house officer or registrar from the on call firm who deals with referrals from casualty, and it is perhaps easier for him or her to decide on a reasonable admission than it is for the house officer accepting calls directly from general practitioners who might also, quite correctly, be playing safe. We remain convinced that in this particular circumstance admission rates are a reasonable proxy of ill health since the factors that may constrain their validity (many of which have been mentioned in the correspondence) apply equally well to patients referred from all sources.

The time that elapsed between the consultation in general practice and self referral to casualty is not as relevant as has been suggested; patients can choose to reconsult their general practitioner at any time in the event of deterioration, and emergency admission can be arranged directly with on call firms. Despite any delays the patients we describe should not encounter scepticism from staff in casualty when they present.

We did not take into account general practitioners referring patients to casualty and did not use our findings to pass judgment on those who do this. Furthermore, we did not attempt to give elaborate explanations for our findings; the criticism of general practitioners’ diagnostic abilities is implied, although, as with all epidemiological studies, there are many ways of interpreting the results.

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AUTHORS’ REPLY,—The use and abuse of accident and emergency departments clearly remains an emotive, important, and controversial subject. The authors showed that, in Nottingham, adults with a given complaint who have seen their general practitioner before they refer themselves to an accident and emergency department are just as likely to be admitted as other attenders; thus we caution against any scepticism that may be directed towards them in the casualty department. Though Michael Dixon reasonably suggests that patients can “wind up” doctors into admitting that it is unreasonable to assume that this occurred more commonly in one particular group of attenders in our study; thus its effect is unlikely to have altered our conclusions.

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Oesophageal atresia mistaken for anorexia nervosa

EDITOR,—P D Duane and colleagues present a cautionary tale of mistaken diagnosis—achalasia mistaken for anorexia nervosa in emaciated young women—and point out that their patients lacked the distorted body image and the distorted mental image that are characteristic of primary anorexia nervosa.

Their story captures the essence of Gall’s remarks at the BMA’s annual meeting in 1868 when he first referred to the condition he then called hysteria anorexia,1 but later called anorexia nervosa.2 He spoke of the need to diagnose medical conditions by their “cardinal facts” and said, “We avoid the error of supposing mesenteric disease in young women emaciated to the last degree through hysterical aepsea, by our knowledge of the latter affection, and by the absence of tubercular disease elsewhere.” Doctors now should try to avoid the error of supposing anorexia nervosa in young women emaciated from mesenteric disease by their knowledge of anorexia nervosa and the absence of its cardinal facts.

When Gull made his presentation to the Clinical Society and first used the term anorexia nervosa he had to deal with his audience’s perception that localised oesophageal disease was the cause of the syndrome.3 One of his listeners remarked that “twenty years ago these cases used to be sent to Mr MacKenzie”—the English laryngologist who figured so prominently in the unfortunate affair of Crown Prince Frederick of Germany’s throat cancer.

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2 Gull WW. The address in medicine delivered before the annual meeting of the BMA at Oxford, January 1868.


4 Clinical Society. Medical Times and Gazette 1873;2:54-6.

Value of routine ultrasound scanning

EDITOR,—Carole A Luck’s study of routine ultrasound scanning shows the acceptability of routine scanning to be high and the sensitivity to be 85%.1 But the results are to some extent biased by the inclusion of many minor renal malformations of doubtful importance, which masks the fact that only just over a third of cardiac malformations were detected. This emphasises the importance of moving away from overall figures when quoting the predictive value of various methods and reflects the weaknesses of ultrasound screening. If the