

test is comparable, the specificity of the test in children is only 76% compared with 96% in adults.<sup>2</sup> In a retrospective analysis of 190 children, faecal calprotectin was positive (above 50 ng/g faeces) in 91 children of the control group with IBS, non-specific colitis, post-infectious enteropathy, cows' milk/wheat intolerance, pinworms/enterobius, allergic enteropathy, food allergies, worms, coeliac disease, miscellaneous, or no pathology identified, with a median of 65 µg/g faeces in the non-IBD control group (range 20–235).<sup>3</sup> To achieve a comparable specificity of 95% the sensitivity would decrease to 73% with a cut-off for the test as great as 800 µg/g faeces.

We welcome very much all efforts to diagnose IBD much earlier in children. As practical advice, we recommend the referral of children with results >50 mg/g to a paediatrician, and certainly with results of >800 ng/g, or all children with a high clinical suspicion of IBD directly to a paediatric gastroenterologist.

To enable a rapid assessment of children with red-flag signs, the GP's thoroughness in providing all necessary clinical information (symptoms, growth/height/percentiles and documented changes, stool frequency, consistency, blood in stool), family history, and blood test results (full blood count, C-reactive protein, erythrocyte sedimentation rate, albumin, urea + electrolytes, tissue transglutaminase with immunoglobulin A levels) is essential for prioritisation and eligibility for endoscopy. To avoid unnecessary endoscopies or inadequate prioritisation, these data need to be communicated widely to GP teams.

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## The FGM enhanced dataset: how are we going to discuss this with our patients?

In October 2015, the female genital mutilation (FGM) enhanced dataset begins collecting data from GP surgeries about women who have experienced FGM. Reading the information sent to my GP surgery about this dataset,<sup>1</sup> the correspondence in the *BMJ*,<sup>2</sup> the *BJGP*,<sup>3,4</sup> and online,<sup>5</sup> I am concerned about the requirement to submit personal information about my patients without their consent, and managing my fair processing requirements.

Mostly though I find myself wondering how this conversation will be experienced on the clinical front line.

For many of the women I see in my GP surgery, when I ask about whether they have experienced FGM (been 'cut' down there, or closed), it may be the first time they have spoken about it to a doctor. I am mindful that I need to be aware of the possible psychological and physical sequelae of FGM, including pain, depression, and PTSD. Furthermore, I am aware that many have had complex, often harrowing journeys to the UK. I aim to establish a trusting patient-doctor relationship, before embarking on this conversation.

The Bristol PEER study found that 'from the discussions with the women, it was clear that confidence and trust in the health services was minimal'<sup>6</sup> and that 'most of them felt discomfort in confiding in their doctors especially on such a sensitive issue such as FGM'.<sup>6</sup> When, during this sensitive and difficult process, do I mention the dataset? Before I ask her to describe an event that has usually impacted hugely on her throughout her life, from childhood to adulthood, marriage to motherhood? Or do I wait until she tells her story, then thank her and inform her that I now need to talk about informing HSCIC? Can I put myself in her shoes and try to imagine this conversation? What might it mean for her? And how will I feel as a health professional having to discuss this?

It seems inevitable to me that clinicians and women will respond to this government requirement by neither asking nor telling, so avoiding a difficult situation. However, this would counter the efforts made to encourage FGM disclosure, and reduce the opportunities to offer support to women or

safeguard their children.

We must reflect on the conversations we will need to have: will this help tackle FGM?

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## Conflict of interest


GP member of Oxfordshire FGM operations group/ GP lead for FGM. Co-recipient of a small grant undertaking a pilot project in co-designing research into experiences of FGM.

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## Meetings between experts

I greatly enjoyed Dr Snelson's piece and would like to share my experiences as GP tutor in Central Manchester.

We called our GP education sessions 'meetings between experts' to emphasise that GPs are specialists and experts too.



All speakers had an educational brief. This set out the concerns and questions about the proposed subject from a GP's point of view. (For example, not 'Ménière's disease update', but rather what are the useful signs and symptoms to confirm or refute the diagnosis in primary care? Is there a risk of overdiagnosis? Is referral needed or not?) At the session, participants were invited to raise their learning needs, reflections, and concerns before the speaker started.

Speakers were instructed to prepare not more than 20 minutes worth of talking so that the rest of the time would be taken up with discussion, where the real learning occurred. Some speakers were puzzled or hesitant at first, but soon realised the benefits, and many commented afterwards that they had learned far more themselves. The record shortest time a speaker managed was about 15 seconds, when the evidence base for a statement they made was challenged from the floor as to its accuracy and applicability to primary care. The debate was lively!

Occasionally speakers had to cancel at the last minute; we used a crowdsourcing method then. Putting together the questions from the floor and sharing the knowledge in the room from attendees meant really useful learning happened with no 'expert' in sight.

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## Addendum

In the October article by Astin MP *et al.* Diagnostic value of symptoms of oesophagogastric cancers in primary care: a systematic review and meta-analysis. *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X686941, the authors would like to add the following text to the penultimate sentence of the abstract's Results section: 'Sensitivity was lower for: anaemia 0.12 [95% CI = 0.08 to 0.19] with specificity 0.97 [95% CI = 0.94 to 0.99]; nausea/vomiting/bloating 0.17 [95% CI = 0.05 to 0.46] and 0.84 [95% CI = 0.60 to 0.94] respectively; reflux 0.23 [95% CI = 0.10 to 0.46] and 0.70 [95% CI = 0.59 to 0.80]; weight loss 0.25 [95% CI = 0.12 to 0.43] and 0.96 [95% CI = 0.88 to 0.98].'

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