4 Smith GB, Prytherch DR, Watson D *et al.* S_pO_2 values in acute medical admissions breathing air – implications for the British Thoracic Society guideline for emergency oxygen use in adult patients? *Resuscitation*. Submitted for publication.

Response

We thank Professor Smith and colleagues for their interest in our paper. We note with interest that their unpublished work has confirmed our hypothesis that the sensitivity and specificity of existing early warning systems (EWS) are reduced amongst patients with underlying respiratory disease compared with unselected medical patients. We agree that further refinements to our proposed modified scoring system that allocates EWS points based on oxygen saturation will be required. We are currently testing a few different models of EWS oxygen scoring for respiratory patients and general medical patients, and we look forward to working with the Royal College of Physicians team and with Professor Smith and colleagues on developing evidence-based EWS models that will enhance the care and safety of patients with chronic respiratory disease who require hospital admission.

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Interventional procedures: physician involvement enhances clinical coding

Editor – The study by Hogarth *et al* (*Clin Med* April 2012 pp189) demonstrates marked improvement in coding and financial outcomes by better collaboration between clinicians and coders in the setting of electrophysiology and device procedures.[1] This is also generalisable to other interventional procedures, particularly as they tend to attract higher tariff and are typically performed in high volume as they generally require expertise in particular centres with sufficient patient flow, and hence the potential for financial disparity if these are miscoded is much higher. The principal requirement for success here is for better collaboration between clinicians and coders, although this can be achieved in different ways.

Indeed there is an unmet need for this, as the Audit Commission has noted that coding inaccuracies seem to be particularly prevalent in interventional specialties with significant national variation between 0.3% and 52% across acute trusts in England.[2] In the field of interventional pulmonology, endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) is performed in high volume in a number of centres. EBUS-TBNA attracts a far higher specific tariff than conventional fibreoptic bronchoscopy: nearly seven times more (£3404 (E63.2 + T87.4) versus £504 respectively).[3]

We (as well as the Audit Commission) have also previously demonstrated significant inaccuracies in coding in the field of interventional pulmonology, with >15% coding inaccuracy in a single centre for EBUS-TBNA and >68% inaccuracy for local anaesthetic thoracoscopy, with estimated financial discrepancies of at least £65,000 for one procedure in one centre annually.[4,5] We have managed to prevent all EBUS-TBNA coding errors by electronically notifying all procedures anonymously to a key member of the coding team after each procedure session, verified by independent cross-checking of the tariff applied and a monthly checklist from the coding team.[6] This has now resulted in estimated savings of £78,000 for the last 165 EBUS-TBNA procedures (projected from the original error rate and cost saving).

In summary, small changes in collaborative behaviour between clinicians and coders in interventional specialties have the potential to make large cost savings even for one procedure alone, and can reduce financial disparity and are worthy of consideration. We therefore endorse the intervention by Hogarth *et al* and suggest this may be of particular relevance to other interventional specialties.

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Rocket scientists need not apply

Editor – We wholeheartedly agree with your recent editorial.[1] Like the hospitals studied by Barton *et al*[2] we fortunately have few serious medication incidents (mainly due to pharmacy intervention), but a good deal of 'low level crime' in terms of legibility and allergy documentation, in addition to other areas. The causes are varied. Clinician training in practical pharmacology (one to two years part time versus five years) is minimal

compared to hospital pharmacists and drug knowledge is limited. A recent survey of our trainee doctors showed that 8/44 did not realise Tazocin was a penicillin and 7/44 thought meropenem was. Similar problems have arisen with Timentin. To compound the issue, only 10/44 trainees said that their consultants checked the drug chart on a ward round 'nearly all the time' or 'all the time'. Unfortunately, our nursing colleagues are often the healthcare professionals disciplined for prescribing errors.

We have used regular updates on our intranet, mandatory briefings, individual and consultant reflection, free hospital name stamps and laminated lanyard 'credit card' aide memoires, all with limited success. Benefits from a post-take ward round checklist have been demonstrated elsewhere.[3]

A national drug chart (as in Wales)[4] would be useful. Electronic prescribing may not be the cure-all that is hoped for and it will need the same national evidence-based approach. In addition, medical students need to get first-hand experience of hospital pharmacy, prescribing practice and nurse dispensing. Review of the drug chart should be standard ward round practice and organisations should have standard feedback mechanisms for prescribing errors.

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An unusual cause of bleeding in an elderly patient

Editor – We read the recent case report on acquired haemophilia A with interest (*Clin Med* April 2012 pp150–52). As a rare condition occurring mainly in the elderly (median age 73.9 years) it often presents to the general physician.[1]

The authors correctly state that the first aim of treatment is to control bleeding. However, this patient presented with two life-threatening bleeding events and was seemingly not treated with haemostatic bypassing agents on the basis that the intensity of treatment and monitoring would not be in the patient's best interest. Good haemostatic responses are seen with both bypassing agents: factor eight inhibitor bypassing activity (FEIBA) and recombinant factor VIIa (r-FVIIa)(Novoseven®); both are given as simple infusions. Subsequent immunosuppression to eradicate the underlying inhibitor results in complete responses in 58% and 80% of patients treated with either steroids or steroids and cyclophosphamide respectively, with good responses (>50%) seen to second-line treatment.[2]

Although it is useful to highlight this rare condition, we feel that some of the messages to the general physician with regard to the management of this case are misleading. Firstly, initial treatment of bleeding is rarely contraindicated and may be life or limb saving. Early liaison with a haemophilia comprehensive care centre is crucial to expedite expert management. Viral transmission from plasma-derived FEIBA has not been reported and a recombinant alternative exists (Novoseven®). Readers should be reminded that an abnormal activated partial thromboplastin time (APTT) should never be dismissed, regardless of a normal prothrombin time (PT). Also, a prolonged PT fails to identify the most common inherited disorders of haemostasis (von Willebrand disease, haemophilia A & B and factor XI deficiency).

Acquired haemophilia is a rare, but treatable condition affecting a predominantly elderly population likely to have complicating comorbidities. With modern treatment approaches the outlook from the point of view of treatment of bleeding events and suppression of antibody production is good, but requires prompt diagnosis and treatment. Patients and relatives require clear and up-to-date information about treatment options available to make informed decisions.

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2 Collins P, Baudo F, Knoebl P *et al.* Immunosuppression for acquired hemophilia A. Results from the European Acquired Haemophilia Registry (EACH2). *Blood* 2012. Apr 18. [Epub ahead of print]

Erratum – the authors of the original article (*Clin Med* April 2012 pp150–52) have pointed out that an error crept into their manuscript. It is deficiencies of