

micronutrient deficiency in an individual from a vulnerable population group should trigger consideration of other subclinical micronutrient deficiencies that may be less apparent.

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Clinical & scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Early intervention can influence an outcome – time to introduce an alert system for all cancer patients?

The National Chemotherapy Advisory Group 2009 report¹ emphasised the need for all hospitals with an emergency department (ED) to establish an acute oncology service (AOS). An AOS brings together expertise from oncology disciplines, emergency medicine, general medicine and general surgery. An effective team is one which carefully coordinates care and communicates well.

We have introduced a cost-neutral patient alert system developed by simply linking the hospital number of all known oncology patients to the patient administration system (PAS). Every 24 hours a report is compiled of all tracked patients who have both attended and been admitted via the ED. This report is sent to all members of the acute oncology team (AOT) daily.

The value of such an alert system is epitomised by a case which presented over one weekend: a 40-year-old man known to the local oncologist, having recently undergone hepatic resection of colorectal liver metastases after resection of his primary, following neoadjuvant chemotherapy. He presented with a short history of headaches. He was discharged with simple analgesia with no plans to further investigate or refer back to his oncology team. This seemed highly appropriate as cerebral metastases are not typical of metastatic bowel cancer.

An alert of his attendance was received on Monday morning and followed up by the AOT by calling the patient at home to enquire further about the symptoms. An

outpatient appointment was made for further investigations. Within four days of presentation to the ED, a magnetic resonance imaging (MRI) head scan was performed as his history was suggestive of an acute neurological event. The MRI revealed a two-cm solitary enhancing lesion within the right cerebellar lobe with local mass effect and effacement of the fourth ventricle. He was started on high-dose dexamethasone and his case referred to the specialist neurosurgical service. He underwent a cerebellar metastectomy, histology of which confirmed a sigmoid metastasis. He recovered within days of surgery and has returned to work.

This case illustrates the need for robust systems to ensure that oncology patients are appropriately identified for any new symptoms which may indicate recurrent disease, particularly out of hours. If his isolated cerebellar metastasis was not detected early, as described above, he may have presented following a catastrophic bleed not amenable to a potentially curative procedure.

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Where there is no resident neurologist: a case for a neurology attachment for acute medicine trainees

Acute neurological problems account for 15% of the general unselected medical take and

where there are no resident neurologists, general physicians care for these.¹ In one third, the diagnosis remains uncertain or is inaccurate.² With the new acute medicine curriculum, there is limited scope for trainees to rotate outside the prescribed core specialties, and this is a potential training flaw.

The previous acute medicine specialist registrar rotation in Wales had a six-month 'elective period' for trainees to pursue other medical interests. One former acute medicine trainee (LA) spent two months of his 'elective' on attachment in a tertiary hospital neurology unit. The attachment included weekly participation at four outpatient clinics (neurovascular, epilepsy, rapid access and general neurology); neurophysiology and neuroradiology sessions, inpatient ward work and seeing urgent referrals from primary and secondary care. The case mix encountered is described in Table 1.

This experience has been invaluable in this former trainee's current role as a consultant acute physician, part of which is in

the ambulatory care unit of a small district general hospital where, in eight months, 40% of the 730 patients seen were referred with a neurological problem. Of these, acute onset headaches were the biggest group (30%) and transient ischaemic attacks and first seizures accounted for 20% each. Of those presenting with acute onset headaches, the most common diagnosis (in one third of headache cases) was migraine.

Incorporating neurology into acute medicine training programmes is extremely useful. It helps the non-neurologist handle the immediate issues more confidently, and to refer appropriately. The increasing use of thrombolysis for acute stroke will only increase the demand for front-line clinicians who are confident in the diagnosis of acute neurological deficits.

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The preference of general practitioners for structured outpatient clinic letters

Background

Clinic letters are the primary method of communication between the hospital specialist and GP. Letters convey advice on management and are also an important part of the clinical record providing a summary of the consultation. Despite this, very little is known about the style of letters written by most hospital specialists (including dermatologists) and the preferences of GPs.

Some hospital specialists advocate the use of structured clinic letters, which include a list of diagnoses and problems with investigations, treatments and follow-up under subheadings. A growing body of evidence shows that GPs prefer to receive structured clinic letters from hospital specialists including paediatricians^{1–3} and orthopaedic surgeons.⁴

The aim of this study was to find out whether GPs prefer to receive structured or unstructured clinic letters from dermatologists.

Method

An electronic two-question questionnaire was sent to all general practice managers in

Table 1. Cases encountered during attachment in tertiary hospital neurology unit.

Conditions seen in outpatient department clinics	Conditions seen on neurology ward
<ul style="list-style-type: none"> • Acute disseminated encephalomyelitis • Benign intracranial hypertension • Benign positional paroxysmal vertigo • Traumatic brain injury 	<ul style="list-style-type: none"> • Anterior spinal artery infarct • Acid Maltase deficiency • Benign intracranial hypertension • Chronic inflammatory demyelinating polyneuropathy
<ul style="list-style-type: none"> • Cerebellar paraneoplastic syndrome • Cerebrovascular disease • Epilepsy and other causes of seizures • Guillain-Barre syndrome • Hereditary spastic paraparesis • Headache (variety of diagnoses) 	<ul style="list-style-type: none"> • Cranial nerve (isolated) palsies • Carotid artery dissection • Epilepsy and pseudoseizures • Guillain-Barre syndrome • Headache (variety of diagnoses) • Idiopathic sensory axonal neuropathy
<ul style="list-style-type: none"> • Mononeuritis multiplex (Churg Strauss syndrome) • Multiple sclerosis • Migraine • Motor neurone disease • Neurosarcoidosis 	<ul style="list-style-type: none"> • Leukoencephalopathy • 'Locked in' syndrome • Multiple sclerosis • Normal pressure hydrocephalus • NMDA-antibody-mediated encephalopathy
<ul style="list-style-type: none"> • Neurofibromatosis type 1 • Occipital neuralgia 	<ul style="list-style-type: none"> • Neuroendocrine tumour • Progressive multifocal leukoencephalopathy • Paraproteinaemic neuropathy • Spinal dural arteriovenous fistula • Stroke (post thrombolysis) • Transverse myelitis
<ul style="list-style-type: none"> • Peripheral neuropathy • Parkinson's disease • Syncope • Venous sinus thrombosis 	