letters to the editor

Please submit letters for the editor's consideration within three weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

Improving perioperative diabetes care

Editor – While strongly agreeing with Dr Flanagan's summary of enhancing perioperative diabetes management (*Clin Med* Feb 2011 pp 63–4), one feels that there is more to be said on the subject of surgical pre-assessment for elective surgical patients. Pragmatically, surgeons (and anaesthetists) should recognise the significance of suboptimally controlled diabetes prior to any intervention or procedure. The best, simplest test for this in the setting of the surgical pre-assessment clinic is the glycated haemoglobin (HbA_{1c}). Audits have shown that a significant number of patients with diabetes do not have their HbA_{1c} checked or recorded in the three months prior to surgery. A simple system of including HbA_{1c} in the pre-assessment checklist means there is scope for rapid, onward referral to the local diabetes multidisciplinary team for optimising their glycaemic control. The global benefits; improved short- and long-term control, reduced surgical complication and infection rates as well as reduced length of stay because of greater glycaemic stability could all potentially stem from this one consideration.

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Acute medicine – an alternative take (1)

Editor – As a GP who is also interested in the interface between primary and secondary care, I enjoyed Michael Houghton's recent article (*Clin Med* Feb 2011 pp 26–7). I would encourage him to develop the role he is exploring as a GP in an acute setting. Houghton explores the difference in philosophy between general practice and hospital medicine. I would like to commend Marinker's[1] exposition in this respect which other readers might also finding interesting. Markiner wrote 'the role of a GP is to tolerate uncertainty, explore probability and marginalise danger; while the role of the hospital specialist is to reduce uncertainty, explore possibility and marginalise error.' I believe this might be helpful in understanding the different approaches to the use of investigations, and clinical risk management between GPs and consultants.

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Reference

1 Marinker M. *General practice and the social market*. London: Social Market Foundation, 1989.

Acute medicine – an alternative take (2)

Editor – The article on 'acute medicine – an alternative take' (*Clin Med* Feb 2011 pp 26–7) suggests we should employ GPs for £450 a day (or more) as GPs with special interests (GPwSIs) in acute medicine. This comes a month after an article suggesting that by 2014 we will have a massive surplus of certificate of completion of training holders across all the main medical specialties. The compelling reason to employ a GP in a hospital setting on a higher salary than a newly employed consultant is apparently experience. I would suggest we are profoundly underselling the experience of five long hard years as a medical registrar working out of hours if we feel experience as a GP is more valuable than this training. I am not saying we should be protectionist but we need to be clear about the value of a trained consultant. Unless GPwSIs provide clear and compelling evidence, rather than anecdote, to support them working in an environment outside their original training, we should invest in expanding the consultant workforce and employing consultants in acute and general medicine. Furthermore, the lack of a formalised training programme or qualification for GPwSIs means that we should be extremely cautious about extrapolating results from small enthusiastic units. If the GP (himself FRCP, FRCGP) demonstrates successful outcomes, does this really mean this can be reproduced by every GP with an interest in acute medicine?

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A patient with recurrent oedema of the hands and a collapse

Editor – I had a correction to make in the case report by Chowdhury *et al* (*Clin Med* Feb 2011 pp 65–6) regarding the dose of steroid needed to treat polymyalgia rheumatic (PMR). The usual dose of prednisolone for PMR is 15 mg/day and not higher as wrongly suggested by the case report. In the case of RS3PE the usual starting dose is in fact not more than 7.5 mg per day. I feel this is important to point out since being a rheumatologist and an acute physician, I have found patients in the acute admission unit, who have been diagnosed to have PMR, are started on high doses of prednisolone by the acute physicians. The only reason to prescribe a higher dose than 20 mg per day would be if patients presented with features suggesting temporal arteritis, such as temporal headaches, scalp tenderness, jaw claudication and associated problems with vision.

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