

Table 1. Dependency and care costs on admission and discharge.

Outcome	Admission median (IQR)	Discharge median (IQR)	Z-score p-value
NPDS	7 (2–14)	1 (0–5)	–6.842 <0.001
Cost of care (£ per week)	234 (168–564)	102 (18–168)	–6.851 <0.001

NPDS = Northwick Park Dependency Score.

The interim analyses are presented in Table 1 and demonstrate both substantial improvements in independence, and reductions in care costs. We would strongly encourage other rehabilitation teams to collect and collate data for commissioners to demonstrate the effectiveness of multidisciplinary rehabilitation programmes.

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Diagnosis and management of urinary infections in older people

Congratulations to Drs Woodford and George for a well researched article on urinary infections in older people (*Clin Med* Feb 2011 pp 80–3), a common diagnosis encountered during most medical takes. As their article states, urine samples may be hard to obtain in older patients due to incontinence or cognitive impairment, but misdiagnosis of urinary tract infections may result in inappropriate exposure to antibiotics and delay in establishing the correct diagnosis, and urine culture 'if possible' is advised in the appropriate clinical context.

It would have been of interest to review any evidence base, techniques or recommendations for obtaining the urine culture in this commonly encountered subset of patients. Much is written in the paediatric literature about collection of urine by collection bags, supra-pubic aspiration, or 'in-out' catheterisation in young children who are not able to provide a sample easily, and it would be useful to know if these techniques may also have benefit in the adult population.

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Clinical and 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Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section.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.

The need for dedicated dermatology beds

Increasing pressure on inpatient beds has no doubt contributed to the ongoing reduction in designated dermatology beds within acute hospital trusts. Studies in Scotland¹ and Manchester² have highlighted an 82% and 57% reduction respectively in dedicated dermatology beds in recent years. This loss of acute beds for the treatment of patients with severe skin disease has led to a shift away from patient admission towards management in the community with expensive immunosuppressant therapies associated with potentially serious side effects.

We report a study from a designated 12-bedded dermatology ward at Amersham General Hospital in Buckinghamshire, which investigated the impact of admission on the Dermatology Life Quality Index (DLQI)³ of patients with skin disease.

In total, 107 patients were admitted to the ward over a six-month period. Fifty-four per cent (58/107) were female and 46% (49/107) male. The average age was 53.8 years (range 16–94 years). The mean length of stay was 13.9 days (range 2–57 days). Fifty-two per cent of admissions to the ward were planned (eg photoinvestigations, eczema clearance and education) and 48% were emergency admissions (eg acute flares of eczema, psoriasis or cellulitis). The average DLQI score at time of admission was 12 (range 0–30). Three months post-discharge, the average DLQI was 6.5 with an individual average 5.8 point reduction in DLQI score (paired t test, $p=0.0001$).

Improvement in quality of life was greatest in patients with immuno-bullous disease, psoriasis and eczema.

The number of dedicated dermatology beds continues to fall despite evidence of their ongoing need.⁴ An audit of 280 admissions in Manchester² over a six-month time period showed that an alternative to admission was only possible in 8.4% of cases. We conclude that designated dermatology ward beds have a significant impact on the quality of life of patients and this effect seems to be sustained for at least three months post-discharge. Inpatient care for dermatological patients remains essential. Ward closures are likely to seriously impact quality of care outcome measures for patients and the future training of healthcare professionals in the specialty.

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- 3 Finlay AY, Khan GK. Dermatology Life Quality Index (DLQI): A simple practical measure for routine clinical use. *Clin Exp Dermatol* 1994;19:210–6.
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Sub-optimal H1N1 vaccine uptake by immunocompromised inflammatory bowel disease patients

While the published independent review on the H1N1 vaccine during the 2009 pandemic concluded that UK strategy used in the management of the pandemic was

highly satisfactory,¹ results of an audit on immunosuppressed inflammatory bowel disease (IBD) patients carried out at St George's Hospital, London, suggests that delivery of the vaccine to high risk groups was suboptimal. It is well known that patients with chronic conditions, such as IBD, who are treated with long-term immunosuppressive agents, are at increased risk of developing infections.²

During the H1N1 pandemic, the British Society of Gastroenterology (BSG) recommended H1N1, seasonal flu and pneumococcal vaccination for people between the ages of six months and 65 years who are on immunosuppressive drugs including prednisolone (dose of more than 20 mg/day), azathioprine, 6-mercaptopurine, methotrexate, infliximab and adalimumab.³

To assess patients' uptake of the recommended vaccines, especially the H1N1 vaccine, and reasons behind non-vaccination, an audit was performed on patients attending the IBD clinic at St George's Hospital from December 2009 to May 2010.

The 89 patients (47 males and 42 females) who answered the self-administered, structured and confidential questionnaire were eligible for vaccination as per the BSG guidelines and all were on immunosuppressant drugs, the most common being azathioprine (64/89) and prednisolone (31/89). Our data analysis showed that in spite of the H1N1 pandemic, vaccine uptake was suboptimal.

Of the 89 patients, only 25 (28.1 %) were vaccinated against swine flu. Of the 64 unvaccinated patients, 33 (51.6%) were concerned about its side effects, while 11 (17.2%) were unaware of the vaccine's existence and nine (14.1%) were not worried about getting infected. Pneumococcal vaccine showed a similarly low uptake as out of the 89 patients, only 29 (32.5%) were vaccinated. Of the 60 unvaccinated patients, 25 (41.7%) were unaware of this vaccine's existence, seven (28.3%) were concerned about its side-effects, while eight (13.3%) did not believe its effectiveness. Vaccination against seasonal flu had a better uptake, as out of the 89, 53 (59.5%) were vaccinated. Among the 36 unvaccinated patients, 23 (63.8%) were concerned about its side-effects and 11

(30.5%) were not worried about getting infected.

These results suggest that even in a pandemic, immunocompromised patients are abstaining from taking up the recommended vaccines and that this is likely due to a combination of lack of patient awareness of the advised vaccinations as well as scaremongering regarding their side-effects. Primary and secondary care physicians should focus on addressing these factors behind non-vaccination by improving patient education.

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Emergency visits after recent percutaneous coronary intervention

Percutaneous coronary intervention (PCI) is now standard treatment for the majority of patients with acute coronary syndromes or limiting stable angina. In 2008, 80,331 procedures were performed in the UK.¹ Most patients are discharged within 24 hours. While there is mandatory collection of data on major inpatient complications following PCI, less is known about symptoms experienced in the early post-discharge period. General practitioners (GPs) and acute physicians will usually undertake the initial assessment of these patients.

We undertook a retrospective analysis of the 30-day outcomes of the first 150 patients undergoing PCI in our new centre between September 2009 and May 2010. Sixty-five per cent of cases were performed electively and 92% of these as