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 Manchester[2] 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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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

day-case procedures. In total, 100% follow-up data were obtained by telephone calls (62.7%), clinic visit (19.3%), postal questionnaires (17.3%), and calls to the GP (0.7%). Any complication was fully investigated with review of the medical records. Major adverse events (myocardial infarction (MI), stroke, revascularisation or all cause mortality) occurred in 2.7%, but only one such event (0.7%) occurred after discharge from cardiology care (ST segment elevation MI (STEMI) in a patient non-compliant with clopidogrel). Within 30 days of discharge, however, 14.7% (22) of patients sought medical help. In the majority, 9.3%, this was due to chest pain (Table 1). All nine of the 'atypical chest pain' patients presented between Days 1 and 7. Discharge diagnoses included: 'atypical-, non-cardiac-, troponin negative-, anxiety or indigestion/palpitations-chest pain'. None had new enzyme release on their readmission or dynamic electrocardiogram (ECG) changes and most were discharged within a day of re-admission.

In this series one in every seven patients sought medical help within 30-days of discharge, suggesting that UK acute physicians or GPs may see more than 10,000 patients per year presenting with symptoms soon after PCI. The majority presented with chest pain but this symptom rarely indicated MI or ischaemia.

The aetiology of the atypical chest pain is unclear. A form of post-PCI syndrome has been previously described. This can range from pain presumed to result from vessel stretch and traumatic wall injury to a true, perhaps autoimmune mediated post-cardiac injury syndrome.[2] Although post-PCI pain is not associated with adverse early outcomes,[3] there is some suggestion that those patients experiencing post-PCI pain are a cohort at higher risk of restenosis.[3]

The acute physician must be aware that the most important early complication of PCI is acute stent thrombosis. This presents in dramatic fashion with severe chest pain and ECG changes but is uncommon (incidence of 0.5-1.0% per annum).[4] Such patients, at high risk of mortality or significant morbidity, need immediate attention from an interventional cardiologist. By contrast the majority of chest pain readmissions soon after PCI are benign and easily diagnosed by clinical assessment and the lack of major ECG abnormality. The symptoms respond to simple analgesia, and further investigation is usually unnecessary.

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Table 1. Problems leading patients to seek new medical help after discharge within 30-days post-percutaneous coronary intervention. [a]Known residual coronary disease/awaiting further PCI procedure; [b]Non-major bleed ñ not requiring intervention.

Representations post-discharge	% (n)
Chest pain – total	9.3 (14)
• atypical chest pain	6.0 (9)
• angina[a]	2.7 (4)
• STEMI	0.7 (1)
Medication side effects	3.3 (5)
Vascular access bleed[b]	1.3 (2)
Gastrointestinal bleed	0.7 (1)

STEMI: ST elevation myocardial infarction

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