

Clinical and scientific letters

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Are upper gastrointestinal cancer two week referrals an appropriate use of National Health Service resources?

The UK Department of Health NHS Cancer Plan set out targets to improve clinical care of patients with cancer in response to poor UK survival rates compared with other developed European countries.¹ One focus was the 'two week rule' (TWR) system for patients with suspected cancer. Primary care physicians who suspect a patient of having cancer are encouraged to refer the patient using a standardised proforma (specific to each speciality) with an obligation for the hospital to see the patient within two weeks. This TWR puts enormous pressure on trusts to accommodate these patients, and hospital managers will take extraordinary steps to meet this target. However there is a paucity of data on outcomes for upper gastrointestinal cancer referrals using the TWR.

We undertook a review of the final diagnosis of patients referred to Barnet Hospital, a district general hospital serving a population of 250,000, using the upper gastrointestinal (GI) North London Cancer Network (NLCN) two week proforma. All upper GI NLCN referral forms received at our institution from April 2006 to October 2007 were analysed for age, sex, presenting symptoms, final diagnosis and treatment.

In total 345 referrals were received with complete outcome data available in 91.6% cases (n=316; female = 55.7%; mean age = 66.9 years). Forty three cancers were diagnosed, of which 36 (11.4%) were upper GI cancers. The types of cancer were oesophageal (n=14), pancreatic (n=13), gastric (n=8)

and cholangiocarcinoma (n=1). The major presenting symptoms were: oesophageal cancer – dysphagia (85%), weight loss (50%) or both (43%); pancreatic cancer – weight loss (61.5%), abdominal pain (38.5%) or obstructive jaundice (38.5%); gastric cancer – weight loss (75%). However only 1.9% of patients had curative treatment (n=6), the remainder receiving palliation with stents, radiotherapy or supportive care.

Patients with suspected upper GI cancer are fast tracked into out patient clinics or endoscopy in an attempt to improve the quality of care and mortality rates in the UK. It is often difficult for GPs to differentiate those patients who could harbour a serious illness from the majority who are likely to have benign disease. Only one in 10 referrals using a proforma with stringent guidelines actually proved to be an upper GI cancer. This detection rate is similar to lower GI cancer yields in the literature.² Furthermore, curative surgery was only possible in less than 2% of all referrals. Given the pressures on specialty managers and clinicians to accommodate TWR, we would suggest that this represents a poor use of limited resources and cannot be considered a success story for the upper GI cancer referral guidelines.

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Outcome of referrals to a community palliative care service: where do patients die?

Introduction

The majority of people are thought to want to die at home, however more than 50% of the UK population die in hospital.^{1,2} Government initiatives in the UK strive to improve equitably the quality of care received by patients and encourage the individual to choose and receive the care necessary to experience death in their preferred place.^{3,4}

Specialist palliative care in the community is often delivered by voluntary sector organisations. Local commissioning arrangements consider quality markers that they recognise against funding provided to such services. In Wales, place of death is considered a quality marker by the commissioners of this palliative care service. This audit compares the actual place of death patients experienced against their preferences.

Method

A proforma was completed upon the death of every patient referred to the service in 2009. The information captured included the preferred and actual place of death, aspects surrounding their end-of-life care and the reasons for admission for those individuals who died as hospice inpatients or in secondary care.

Results

During 2009, 346 patients known to the hospice died, the median number of days patients were known to the service was 71 and the mean 154 days. The most common cancer diagnoses among those patients referred were lung, colon, pancreas and breast.

Fifty-eight per cent of patients specified that their preferred place of death was their current place of living (including home, residential or nursing home, and prison). Of patients who expressed this preference, 65% were able to achieve this. Eighteen per cent identified that they would prefer to be admitted as an inpatient to the hospice for

end-of-life care and 85% achieved this preference. Two per cent of patients identified that they wanted to be admitted to secondary care and no preference was identified in the remainder. During the course of their illness, 55 patients (16%) changed their expressed preference. Further information concerning patients who were admitted for end-of-life care and did not achieve their expressed preferences is outlined in Table 1. Seven per cent of deaths were from patients referred for non-malignant disease; 15 out of 23 of these achieved their preferences for end-of-life care.

Discussion

The proportion of patients achieving their preferences for home and inpatient hospice with this community service compares favourably with those results reported nationally and in other studies.^{1,2} Despite the often unpredictable time course⁵ for patients with non malignant disease the majority of these patients were able to achieve their preferences for end-of-life care.

Review of information collected upon a patient's death enabled the service to present basic information to their commissioners for discussion. The breakdown of information by primary care team and cause of admission enabled the service to consider targets for future areas of education and activity to facilitate more individuals achieving their preferences for end-of-

life care. The number of patients who die at home could potentially be increased if the events which triggered acute admissions are considered as starting points to change health professional behaviour and target social care.

Achieving preferences for end-of-life care are not events which occur in isolation in the community. It involves the primary care team, out of hour's service, local palliative care service and communication with secondary care specialists. Success is a reflection of healthy community services, and not a marker of quality for community teams.

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Clothing maketh the man

Rehabilitation can be defined as 'the reduction of functional deficits without necessarily reversing the underlying biology of the disease'.¹ Although often perceived as 'basic', effective rehabilitation of older patients is a complex and individualised process that requires consideration of many factors including medical illnesses, psychosocial status, environment and possibly clothing.²

For most, dressing is a daily routine that, as well as affording warmth and protection, reflects independence, personality and status. Modified and adapted clothing (eg specialist footwear) may assist in the rehabilitation of specific physical disabilities, but what of the role of everyday clothing in the 'average' older inpatient?

Despite clothing's obvious contribution to 'normality', venture onto any adult ward and chances are that a majority of patients will be attired in pyjamas or gowns. This is more likely to be the case the older the patient. What is the effect of this on older patients? How can we 'buck the trend', thus allowing patients to become individuals with hopes, aspirations and goals?

Current practice is that most people are changed into a hospital gown on arrival in secondary care, a powerful reminder to all that the individual is now a patient. Seemingly a minor point, this 'small' step is the first of many that may lead to the loss of normal functioning and independence. Although possibly acceptable in those who are acutely unwell, failure to actively challenge or reverse this process can be significantly detrimental to the process of rehabilitation, and at worst be considered as a form of neglect or abuse.³ Negative publicity aside, increasing recognition of the needs of frail elderly patients led to the development and publication of the National Service Framework for older people.⁴ Standard 2.8 of the NSF suggests that enhanced person-centred care should allow patients to wear their own clothes if they choose.

Table 1. Triggers for admission in the patients admitted for end of life care who did not achieve their expressed preferences. Number of events in brackets.

Location patient was admitted	Trigger for admission
Hospital	New complaint identified by GP (hospice staff consulted in two of these admissions) (18)
	Exacerbation of existing symptoms (10)
	Fall (2)
	Complication of home chemotherapy (1)
	Unknown (4)
	Blocked catheter, loss of nasogastric tube, blocked stent (3)
Nursing home	Increased social support needed (5)
Inpatient hospice	Uncontrolled symptoms (vomiting, haemorrhage) (4)
	Perceived lack of social care and support (including lack of sitters) (14)