

comments on the bleeding risks in AKI. In response to the points raised:

- 1 Our standard policy in AKI is to use gastroprotective proton pump inhibitor therapy as they suggested. In this case we used lansoprazole 30 mg once daily considering the associated GI bleeding risk given the patient's recent use of non-steroidal anti-inflammatory drugs and the steroid therapy for treatment of his ANCA-positive vasculitis.
- 2 Pulmonary haemorrhage was considered and gas transfer factor was measured (64%). As it was not elevated, we did not mention it in the case report.
- 3 We agree that low-molecular weight heparins may accumulate in renal failure and that their use in AKI is controversial. However, this patient undoubtedly had a higher than usual risk of thrombosis and we therefore selected to use a low dose of daily enoxaparin (20 mg).

On balance, although there is a significant GI and pulmonary haemorrhage risk in AKI and in ANCA-positive vasculitis, this man also had a sizeable risk of thrombosis given his diabetes with hyperosmolality on presentation, AKI and sepsis. We therefore maintain that thromboprophylaxis should be considered in similar cases, given the trial evidence^{1,2} but that this should be balanced against the calculated bleeding risk which should be assessed for each case.

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References

- 1 Montero Ruiz E, Utrilla GB, Alvarez JL, Perrin RS. Effectiveness and safety of thromboprophylaxis with enoxaparin in medical inpatients. *Thromb Res* 2011 (epub ahead of print Aug 29).
- 2 Keenan CR, Murin S, White RH. High risk for venous thromboembolism in diabetics

with hyperosmolar state: comparison with other acute medical illnesses. *J Thromb Haemost* 2007;5:1185–90.

The inpatient neurology consultation service: value and cost

Editor – The paper by Douglas and colleagues emphasises the importance of neurological advice for the diagnosis and management of hospital inpatients with acute neurological disorders (*Clin Med* June 2011 pp 215–17). This is usually available in the district general hospital (DGH) attached to the regional neurology centre but not so readily elsewhere. This can create difficulties since the present default model of management of acute medical emergencies is admission to an acute medical unit (AMU) followed by triage to an appropriate specialist consultant physician. Without neurologists in the DGH, who rarely have inpatient beds, there is nobody for patients with acute neurological symptoms to be triaged to.

The recent report *Local adult neurology services for the next decade* published jointly by the Royal College of Physicians and Association of British Neurologists, draws attention to this inequitable standard of care for patients with acute neurological disorders in many DGHs.¹ It also refers to other evidence² that liaison neurology can halve the length of stay of patients with acute neurological emergencies and result in more accurate diagnosis, confirmed by Douglas *et al*'s paper. One of the major recommendations of the report is that acute neurology services run by neurologists should now be specifically commissioned and provided in the DGH so that patients with acute neurological disorders get earlier access to a neurology opinion and treatment.

Some simple calculations show that rapid access to neurology advice, as well as potentially improving outcomes, would easily pay for the appropriate neurological time by saving costs through reductions in the length of stay and number of admissions. If 120 patients have an average length of stay of four days each, this amounts to 480-bed days per three months at a cost of £72,000 (assuming £150 per bed day). Reducing the length of stay to two days

saves £36,000 per three months or £144,000 per year. Halving these estimates to an average length of stay to two and one day respectively, still amounts to £72,000 per year, more than enough to pay for the necessary neurological sessions.

There are therefore sound financial reasons as well as potential improvements in care if patients with acute neurological disorders are seen by the people best able to look after them, ie neurologists. General physicians, specialist physicians themselves, quite rightly in my experience, see no reason why they should continue to manage patients with acute neurological disorders any longer. This is surely the responsibility of neurologists! The case for acute neurology run by neurologists is incontrovertible and DGH trusts should be encouraged to appoint acute neurologists to do this.

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References

- 1 Royal College of Physicians. *Local adult neurology services for the next decade*. Report of a working party. London: RCP, 2011.
- 2 Forbes R, Craig J, Callender M, Patterson V. Liaison neurology for acute admissions. *Clin Med* 2004;4:290.

In response

We are grateful for Dr Bateman's comments and agree that there are obvious financial, as well as clinical, advantages for patients with acute neurological disorders to be seen by neurologists. It is worth noting that the data from our paper¹ were generated between September and November 2005, at a time when the majority of our inpatient work was based on a ward referral review system, rather than a system of direct admission to neurological care. The service was subsequently reconfigured and patients with acute neurological problems are now first admitted to the medical assessment unit, followed by triage and transfer to the neurology ward. This practice broadly follows the suggestions of the report by the

Association of British Neurologists (ABN) and the Royal College of Physicians (RCP) (although we do not have a 24/7 acute neurology service), but it is worth noting that this leads to a significant increase in consultant activity. The number of inpatients under a consultant neurologist in our hospital during the same three-month time window increased 284% as a consequence from 2005 (91 patients) to 2010 (259 patients), even though there was no change in consultant numbers during this time period. It is worth highlighting that all the consultants involved also have inpatients at the regional neurology centre.

Such changes in working pattern are to be encouraged to fulfil the aims of the ABN/RCP report,¹ but there needs to be adequate planning of the consultant neurology workforce. The Centre for Workforce Intelligence (CfWI)² has recently recommended no change in the

number of neurology training posts – including the so-called ‘Hewitt/Johnson’ training numbers that were awarded on a temporary basis in the midst of Modernising Medical Careers in 2007/8. The CfWI stated that current growth will not meet demand by 2020 and have suggested a review in 2012 as ‘action may be needed to boost supply’.² Yet all 35 (including seven from our own region) of the Hewitt/Johnson posts in neurology are currently due to be removed from August 2012. Unless funding is found for these posts, the ABN/RCP report will very much remain an aspiration, rather than a pathway to better neurological care.

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References

- 1 Royal College of Physicians. *Local adult neurology services for the next decade*. Report of a working party. London: RCP, 2011.
- 2 Centre for Workforce Intelligence. *Recommendations for medical specialty training numbers*. London: CfWI, 2011. www.cfwi.org.uk/intelligence/shape-of-the-medical-workforce-informing-medical-specialty-training-numbers/neurology