

Another strategy to reduce costs would involve addressing the system used to predict length of stay, which suffers from a logical flaw. The trim-point is derived following coding at the time of discharge (as it is influenced by diagnoses, procedures, etc). Therefore, overstay is defined after the event, so cannot be identified, monitored or prevented during the inpatient stay. The coding proformas used to allocate patients to HRGs appear a crude implement; there is considerable ambiguity in categorisation and they are usually filled by staff without specific training.

Addressing these issues has the potential to make large financial savings and improve the hospital inpatient process for patients.

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## Interface geriatrics: modernising conventional geriatric medical care

Nowadays managing elderly acute medical admissions is a big challenge in hospitals as the numbers of patients at age 75 and above admitting to acute medical beds are rapidly growing more than any other age group over the decade. Admissions of this particular age group significantly increased up by two thirds from 2000 to 2010.<sup>1</sup> In this situation, effective acute geriatric assessment and care is more important than before. Therefore, the conventional geriatric med-

ical care should be innovated and modernized to meet the health needs of rapidly growing elderly acute admissions.

A study done by a group of researchers based in Leicester highlighted that elderly patients had risks of long inpatient stay, quick discharge of these patients did not always serve them well and therefore specialist geriatric assessment was needed for better overall outcomes.<sup>2</sup> On the other hand, 55% of elderly frail patients discharging back to the community from acute medical care were readmitted and about 26% died in the following 12 months.<sup>3</sup> All these circumstances pointed that these (elderly) patients should receive comprehensive geriatric assessment on admission and a clear integrated care pathway should also be established in between community and secondary care (acute hospital). These requirements motivated the birth of 'interface geriatrics', the new integrated geriatric care bundle. It can be defined in various ways but its core principles are implementation of rapid comprehensive geriatric assessment to acute elderly admissions in hospital and harmonious combination of hospital and community geriatric cares.<sup>4</sup> A care model of interface geriatrics can be seen in Fig 1.

In this care bundle, all elderly acute admissions such as patients age 75 and above must be promptly seen and assessed by a multidisciplinary geriatric medical team on admission such as in acute medical assessment unit rather than waiting for these patients being transferred to a care of the elderly ward. Implementing this care approach can lead to various benefits in acute care of the elderly such as avoiding unnecessary admission, reducing length of inpatient stay, organising comprehensive discharge care plans, reducing delayed discharge and reducing the risk of re-admission. A mapping review on current studies and trials about interface geriatrics showed that this care pathway could provide pos-

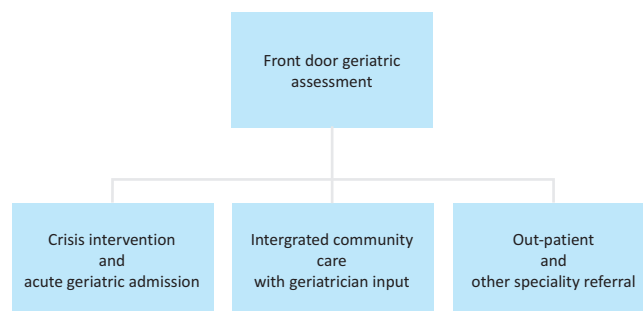


Fig 1. A model of interface geriatric care pathway.

itive outcomes to frail, elderly patients admitting to acute medical beds.<sup>5</sup> The DEED II study, a randomised controlled trial in Australia, conveyed messages that a compressive geriatric assessment integrating primary and secondary cares could reduce readmissions by about 25%.<sup>6</sup> And participation of a geriatrician as a part of a community care team reduced the need of access to acute medical service and unnecessary admission.<sup>7</sup> The cost-effectiveness of an interface geriatric care pathway is not evaluated scientifically so far in various studies but it can be generally justified that such an integrated care pathway provides benefits in term of funding and commissioning.

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## Inadvertent discovery of metastatic lung cancer: an unseen consequence of the introduction of specialist stroke units

The presentation of metastatic lung carcinoma can mimic the features of an acute cerebrovascular event. The development of specialised stroke services to provide rapid thrombolysis of cerebral infarcts has been promoted recently by the NHS.<sup>1</sup> The aim of this study was to see if this has influenced the number of diagnosed metastatic lung carcinomas.

A database of all cases of suspected strokes that presented to a single centre stroke unit was interrogated between September 2009 and August 2010. All cases that subsequently were found to be due to metastatic lung carcinoma on cross-sectional imaging were identified. The even-

tual cell types of any lung cancers identified were noted if available.

In total, 466 patients presented with a suspected stroke during the period in question. Of these, eight (1.7%) were subsequently found to have cerebral/cerebellar metastases from a lung primary. This represented 4.4% of all lung carcinomas diagnosed at our institution (eight of 178 patients). Of these eight patients, five had non-small cell lung cancer, one had a neuroendocrine tumour and two did not have a confirmed tissue type but clinically had a disseminated lung malignancy. Two patients had palliative surgical resections of their cerebellar metastases, the remainder had either cranial radiotherapy or received symptomatic treatment with corticosteroids.

Although these patients with metastatic disease were likely to have had their symptoms investigated even if stroke units did not exist, the creation of streamlined pathways with rapid access to cranial computed tomography scanning has undoubtedly reduced the time to diagnosis. This is one of the major goals for improving the outcome of lung cancer.<sup>2</sup>

Specialised stroke units were originally designed to provide rapid treatment for stroke patients and improve their long-term

outcomes but it is believed that they are having an inadvertent positive effect on the management of metastatic lung carcinoma. However, this may have consequent resource implications for local lung cancer services.

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