compared to hospital pharmacists and drug knowledge is limited. A recent survey of our trainee doctors showed that 8/44 did not realise Tazocin was a penicillin and 7/44 thought meropenem was. Similar problems have arisen with Timentin. To compound the issue, only 10/44 trainees said that their consultants checked the drug chart on a ward round 'nearly all the time' or 'all the time'. Unfortunately, our nursing colleagues are often the healthcare professionals disciplined for prescribing errors.

We have used regular updates on our intranet, mandatory briefings, individual and consultant reflection, free hospital name stamps and laminated lanyard 'credit card' aide memoires, all with limited success. Benefits from a post-take ward round checklist have been demonstrated elsewhere.[3]

A national drug chart (as in Wales)[4] would be useful. Electronic prescribing may not be the cure-all that is hoped for and it will need the same national evidence-based approach. In addition, medical students need to get first-hand experience of hospital pharmacy, prescribing practice and nurse dispensing. Review of the drug chart should be standard ward round practice and organisations should have standard feedback mechanisms for prescribing errors.

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References

1 Hodgson H. Rocket scientists need not apply. *Clin Med* 2012;12:103–4.
2 Barton l, Futtermenger J, Gaddi Y *et al.* Simple prescribing errors and allergy documentation in medical hospital admissions in Australia and New Zealand. *Clin Med* 2012;12:119–123.
3 Herring R, Desai T, Caldwell G. Quality and safety at the point of care: how long should a ward round take? *Clin Med* 2011;11:20–2.
4 All Wales Prescription Chart, 2011. www.wales.nhs.uk/sites3/page.cfm?orgid=371&pid=47669 [Accessed 18 March 2012].

An unusual cause of bleeding in an elderly patient

Editor – We read the recent case report on acquired haemophilia A with interest (*Clin Med* April 2012 pp150–52). As a rare condition occurring mainly in the elderly (median age 73.9 years) it often presents to the general physician.[1]

The authors correctly state that the first aim of treatment is to control bleeding. However, this patient presented with two life-threatening bleeding events and was seemingly not treated with haemostatic bypassing agents on the basis that the intensity of treatment and monitoring would not be in the patient's best interest. Good haemostatic responses are seen with both bypassing agents: factor eight inhibitor bypassing activity (FEIBA) and recombinant factor VIIa (r-FVIIa)(Novoseven®); both are given as simple infusions. Subsequent immunosuppression to eradicate the underlying inhibitor results in complete responses in 58% and 80% of patients treated with either steroids or steroids and cyclophosphamide respectively, with good responses (>50%) seen to second-line treatment.[2]

Although it is useful to highlight this rare condition, we feel that some of the messages to the general physician with regard to the management of this case are misleading. Firstly, initial treatment of bleeding is rarely contraindicated and may be life or limb saving. Early liaison with a haemophilia comprehensive care centre is crucial to expedite expert management. Viral transmission from plasma-derived FEIBA has not been reported and a recombinant alternative exists (Novoseven®). Readers should be reminded that an abnormal activated partial thromboplastin time (APTT) should never be dismissed, regardless of a normal prothrombin time (PT). Also, a prolonged PT fails to identify the most common inherited disorders of haemostasis (von Willebrand disease, haemophilia A & B and factor XI deficiency).

Acquired haemophilia is a rare, but treatable condition affecting a predominantly elderly population likely to have complicating comorbidities. With modern treatment approaches the outlook from the point of view of treatment of bleeding events and suppression of antibody production is good, but requires prompt diagnosis and treatment. Patients and relatives require clear and up-to-date information about treatment options available to make informed decisions.

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References

1 Knoebl P, Marco P, Baudo F *et al.* Demographic and clinical data in acquired hemophilia A. Results from the European Acquired Haemophilia Registry (EACH2). *J Thromb Haemost* 2012;10:622–631.
2 Collins P, Baudo F, Knoebl P *et al.* Immunosuppression for acquired hemophilia A. Results from the European Acquired Haemophilia Registry (EACH2). *Blood* 2012. Apr 18. [Epub ahead of print]

Erratum – the authors of the original article (*Clin Med* April 2012 pp150–52) have pointed out that an error crept into their manuscript. It is deficiencies of

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factors VIII (**not** V), IX,X, XI and XII that may explain an isolated prolonged APTT, as well as severe von Willebrandt's disease, lupus anticoagulant and unfractionated heparin usage.

Cardiology day case unit: the way to manage chronic cardiovascular conditions cost-effectively in future

Editor – We read with great interest Banerjee *et al*'s clinical practice paper (*Clin Med* April 2012 pp 133–6) on intravenous diuretic day-case treatment (DCIDT) for heart failure patients. DCIDT appears to be a very simple, innovative way to reduce the burden of hospital admissions in heart failure patients.

It is clear that heart failure is a common condition and affects between 1 and 20 per 1,000 of the general population.[1] The prevalence of heart failure is likely to increase in parallel with life expectancy due to the success of medical therapy for conditions such as myocardial infarction and hypertension. This trend is seen across the industrialised world.[2] In this country, heart failure accounts for a total of 1 million inpatient bed-days (2% of all NHS inpatient bed-days) and 5% of all emergency medical admissions to hospital.[3] Hospital admissions because of heart failure are projected to rise by 50% over the next 25 years – largely as a result of the ageing population.[4,5] It is estimated that the total annual cost of heart failure to the NHS is around 2% of the total NHS budget; approximately 70% of this total is due to the costs of hospitalisation.[6,7] Readmissions are common: about one in four patients are readmitted within three months of discharge.[8]

Given these figures, there is an obvious need to develop new management strategies to provide treatment to patients without requiring hospital admission. We believe that several recent developments in the management of chronic cardiovascular conditions could form the foundation of a well-run cardiology day case unit in the future. Such units could dramatically reduce the overall cost of congestive heart failure (CHF) to the NHS. A multidisciplinary approach with heart failure specialists nurses, clinicians and allied health professionals might provide some of the following services.

- *Recognition and monitoring:* A recent systematic review and meta-analysis showed that telemonitoring and structured telephone support appear to be effective interventions to improve outcomes in patients with CHF.[9] However, the recent trials (TIM-HF, Tele-HF) did not show much overall benefit from them. The reason behind this was the flaw in the study design (both control groups were just too well treated to show much between-group difference). Telemedicine may help to recognise patients needing interventions in a day case cardiology unit.
- *Heart failure bio-marker monitoring:* The aim of the PROTECT study was to determine whether treatment aimed at achieving and maintaining amino-terminal B-type natriuretic peptide (NT-proBNP) levels at or below 1,000 pg/ml could improve outcomes in patients with chronic LVSD.[10] An improvement in quality of life and a reduction in the number of cardiovascular events was reported in the NT-proBNP group compared with the standard therapy group. The evidence of this study could be applied in cardiology day case units to monitor heart failure patients.
- *Other interventions:* Enhanced external counter pulsation (EECP) is a valuable outpatient procedure providing acute and long-term relief of anginal symptoms and improved quality of life among a group of patients with symptomatic ischemic heart disease with or without CHF.[11] However, further research is needed in terms of cost-effectiveness of this intervention in CHF patients.
- *Optimisation of cardiac resynchronisation therapy:* Cardiac resynchronisation therapy (CRT) is an established treatment of patients with symptomatic advanced heart failure. 25% of patients with CRT are non-responders. Given the cost related to the device implant and follow-up, the role of the day case unit is to integrate the follow-up of this group with optimisation using echocardiography and device programming, especially in the non-responders.
- *Counselling:* Depression leads to poorer outcomes in patients with heart failure, including increased risk of poor functional status, hospital readmission, and death.[12] Hence, depression screening in cardiology day case units could be a way forward to improve QOL in those suffering from CHF.

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References

1 Sharpe N, Doughty R. Epidemiology of heart failure and ventricular dysfunction. *Lancet* 1998;353:(Suppl. 1):37.
2 Senni M, Tribouilloy CM, Rodeheffer R *et al.* Congestive heart failure in the community – Trends in incidence and survival in a 10-year period. *Arch Intern Med* 1999;159:29–34.
3 National Institute for Health and Clinical Excellence. *CG108 Chronic heart failure: costing report.* London: NICE, 2010.
4 Cowie MR, Wood DA, Coats AJ *et al.* Incidence and aetiology of heart failure; a population-based study. *Eur Heart J* 1999;20:421–8.
5 Davies M, Hobbs F, Davis R *et al.* Prevalence of left-ventricular systolic dysfunction and heart failure in the Echocardiographic Heart of England Screening study: a population based study. *Lancet* 2001;358:439–444.
6 Petersen S, Rayner M, Wolstenholme J. *Coronary heart disease statistics: heart failure supplement.* London: British Heart Foundation, 2002.
7 Stewart S, Horowitz JD. Home-based intervention in congestive heart failure: long-term implications on readmission and survival. *Circulation* 2002;105:2861–6.
8 Cleland JG, Swedberg K, Follath F *et al.* The EuroHeart Failure survey programme – a survey on the quality of care among patients with heart failure in Europe. Part 1: patient characteristics and diagnosis. *Eur Heart J* 2003;24:442–63.

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