

Physician assistants: a personal perspective

Editor – I would like to applaud White *et al* on their departmental evaluation of the introduction of physician assistants (*Clin Med* February 2013 pp15–18). I would like to offer a personal perspective of working with a physician assistant for a year during my first year of cardiology specialty training.

I had the opportunity to work alongside a physician assistant (PA) in my first year as a cardiology registrar. The PA had held the post for just under a year when I joined the department. Their role was to work on the cardiology step-down ward and perform clinical duties such as ward rounds, patient assessment and basic clinical procedures. The PA worked at the level of a senior house officer.

Our unit had an eight-bed coronary care unit, a twelve-bed step-down ward and a variable number of outliers on other wards. The junior medical team consisted of two foundation year one doctors and two or three senior house officers (foundation year two and core medical trainees). This might sound over-staffed, but with a combination of general medical on calls, fixed leave and study leave, the unit generally ran with two junior team members. Due to the European Working Time Directive (EWTD) this meant that team members would change daily. This obviously would affect continuity of care for patients.

The PA offered the only thread of continuity for the ward. Their role was central to the effective delivery of good patient care for our inpatients. I hold the personal view that the PA was the most effective member of the team and I could depend on their clinical assessments and management plans. Moreover, our PA was always keen to learn, would work late, join the registrars with referrals and come to meetings.

In modern medicine continuity of care is often the loser to EWTD. We need high quality PAs to join the multiple professional healthcare team to deliver patient-centred care.

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Churg-Strauss syndrome: remember cardiac complications too

Editor – Llewellyn *et al* describe an important case and overview of Churg-Strauss syndrome (CSS) (*Clin Med* February 2013 pp103–5). In terms of its multisystem involvement, it is important to also consider cardiac involvement, which was not specifically discussed in the paper. Although the patient had a normal echocardiogram and did not display obvious cardiac involvement, it is important to remember this possibility when treating such cases. Cardiomyopathy is the main independent predictor of death in CSS, with a hazard ratio of 4.11 for death after multivariate analysis.¹ In a large recent retrospective series, cardiomyopathy occurred in over 16% of CSS patients, and interestingly anti-neutrophil cytoplasmic antibody (ANCA) negative patients had more cardiac involvement.¹ The median time to death was 14 months from fatal cardiac events after diagnosis with CSS. Vasculitic lesions can occur in the myocardium and coronary vessels with coronary occlusion and subsequent scarring and fibrosis. Cardiac involvement can therefore present as myocarditis, heart failure, valvular disease (especially mitral regurgitation) and pericardial effusion. This can also be compounded by pulmonary hypertension secondary to lung disease.

An observational study of 32 ambulatory CSS patients detected cardiac involvement in 62%.² In those with abnormal cardiac magnetic resonance imaging (MRI), echocardiography could detect cardiac involvement with 83% sensitivity and 80% specificity. In those with echocardiographic abnormalities, cardiac MRI detected cardiac involvement with 88% sensitivity, but only 72% specificity. Notably, 38% of CSS patients had cardiac involvement (on echocardiography or cardiac MRI) despite the absence of cardiac symptoms and a normal ECG (after controlling for diabetes, hypertension and coronary artery disease). Therefore, echocardiography should be used in all CSS patients (cardiac MRI is an alternative but is not always available or practical in a critical care setting).

In summary, it is important for physicians to look beyond symptoms and an ECG for cardiac involvement in CSS with either echocardiography or cardiac MRI as this has prognostic implications.

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References

- 1 Comarmond C, Pagnoux C, Khellaf M *et al*. Eosinophilic granulomatosis with polyangiitis (Churg-Strauss). Clinical characteristics and long-term followup of the 383 patients enrolled in the French Vasculitis Study Group Cohort. *Arthritis Rheum* 2013;65:270–81.
- 2 Dennert RM, van Paassen P, Schalla S *et al*. Cardiac involvement in Churg-Struass Syndrome. *Arthritis Rheum* 2010;62:627–34.

Investigating the frail elderly patient with lower bowel symptoms: what do we do now and can we improve?

Editor – Frailty is increasingly recognized as an important geriatric syndrome related to, but not synonymous with, ageing. It differs from ageing in that it is amenable to both prevention and treatment.¹ Given the improved scientific characterisation of frailty,² it is a pity that the authors of the paper on investigation of the ‘frail elderly’ with lower bowel symptoms (*Clin Med* February 2013 pp 37–41) did not use one of the recognised clinical tools for assessing frailty.

While the judgment of a range of referring physicians, or the treating gastroenterologist, as to fitness for colonoscopy may be a proxy measure for frailty, it may equally be an indicator of ageism given the relative safety of colonoscopy in older people³ and existing evidence of ageism in a range of cancer services worldwide, including bowel investigations.⁴ A formal assessment of frailty would assist in clarifying this issue.

In addition, the continued use of the term ‘elderly’ may not be helpful as it is rarely associated with fit older people, is