

under the heading of 'service evaluation'. It seems 'designed and conducted solely to define or judge current care'. It clearly complies with 'usually involves analysis of existing data but may include administration of interview or questionnaire'.

It is a general point that many of the projects submitted by trainees for REC approval could be classified either under this heading, or as 'clinical audit' – which also does not usually need REC review. If in doubt, the chair of a REC will usually be able to give advice – we're just as happy as the researcher to keep paperwork to a minimum.

This is my personal opinion – I do not speak for NRES!

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## Reference

- 1 National Patient Safety Agency, National Research Ethics Service. *Defining Research*. London: National Patient Safety Agency, 2010. [www.nres.nhs.uk/applications/guidance/research-guidance/?entryid62=66985](http://www.nres.nhs.uk/applications/guidance/research-guidance/?entryid62=66985) [Accessed 29 July 2013].

## PEG placement for patients with oropharyngeal/oesophageal cancers

Editor – I recently read and completed the CME gastroenterology self-assessment questionnaire (*Clin Med* Dec 2012 pp 572–95). Question 3 asks about nutritional support for a patient with a pharyngeal tumour due to undergo radiotherapy and surgery. The answer given is that he should have a percutaneous endoscopic gastrostomy (PEG) sited for feeding.

Endoscopic siting of a PEG tube involves pulling the feeding tube and plastic 'bumper' through the oropharynx, oesophagus, into the stomach and out through the gastrostomy site. This procedure potentially brings the tube and bumper into direct contact with tumours at these sites. Tumour seeding with development of metastases at the PEG site has been reported in numerous case reports<sup>1,2</sup> and metastases of this nature can have devastating consequences for patients.

National guidelines<sup>3</sup> highlight this issue and state that the alternative, direct puncture technique, has not been demonstrated to result in metastases, but they do not go as far as to make recommendations for clinical practice. Most recently a prospective trial has attempted to address this question.<sup>4</sup> Ellrichmann *et al* performed immediate and delayed (after 3–6 months) cytology from PEG tubing and at the transcutaneous incision site of 40 patients undergoing pull-through PEG for ear nose and throat (ENT)/oesophageal cancer. The results were concerning, demonstrating malignant cells on cytology of 22.5% of patients immediately after pull-through PEG placement, and 9.4% of patients with local metastases at follow up. While the authors admit the sample size was small (n=7 studied at follow up), the study demonstrated a shorter median overall survival in those with proof of malignant cells at follow up (16.1 weeks vs 26.8 weeks, p=0.08). The authors note that risk of malignant seeding was highest in older patients and in those with higher tumour stages and concluded that pull-through PEG should be avoided in these groups and direct access gastrostomy favoured instead.

## References

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- 2 Adelson RT, Ducic Y. Metastatic head and neck carcinoma to a percutaneous endoscopic gastrostomy site. *Head Neck* 2005;27:339–43.
- 3 Westaby D, Young A, O'Toole P *et al*. The provision of a percutaneously placed enteral tube feeding service. *Gut* 2010;59:1592–605.
- 4 Ellrichmann M, Sergeev P, Bethge J *et al*. Prospective evaluation of malignant cell seeding after percutaneous endoscopic gastrostomy in patients with oropharyngeal/oesophageal cancers. *Endoscopy* 2013;45:526–31.

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## Managing hyperglycaemic emergencies: an illustrative case and review of recent British guidelines

Editor – In the paper 'Managing hyperglycaemic emergencies: an illustrative case and review of recent British guidelines' (*Clin Med* April 2013 pp160–2) the authors have discussed the difficulties of differential diagnosis between diabetic ketoacidosis (DKA) and hyperosmolar hyperglycaemic state (HHS).

In this discussion, they have omitted an important event: the Nobel Prize of 1977 which went to Rosalyn Yalow for the development of new methods of biochemical analysis, enabling also to measure concentration of insulin in human plasma.

Already in 1981, the monograph *Diabetic coma: ketoacidotic and hyperosmolar*<sup>1</sup> states the names of 12 authors who reported insulin in plasma of patients with DKA. Thus, the statement '... in DKA, the lack of insulin...' is not correct.

On the other hand, lack of plasmatic insulin has been reported in patients with HHS,<sup>2</sup> for example, and even in diabetic outpatients on regular control without subjective complaints.<sup>3</sup> Thus, also the end of the statement on p160 '...in HHS, residual beta cell function is sufficient to prevent lipolysis...' is incorrect.

It is very useful to discuss difficulties in the differential diagnosis of DKA and HHS; however, this discussion would be more exact and more reliable if concrete numerical values of concentration of plasmatic insulin were included.

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- 2 Vinik A, Seftel H, Joffe BI. Metabolic findings in hyperosmolar nonketotic diabetic stupor. *Lancet* 1970;296:797–9.
- 3 Matsuyama T, Hoffman WH, Dunbar JC *et al*. Glucose, insulin, pancreatic glucagon and glucagon-like immunoreactive materials in the plasma of normal and diabetic children. Effect of the initial insulin treatment. *Horm Metab Res* 1975;7:452–6.