Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within three weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

Non-uraemic calciphylaxis – an unexpected differential diagnosis for a necrotic ulcer

Editor – Calciphylaxis, first described by Selye in 1962, is also referred to as calcific arteriolopathy or calcification-cutaneous necrosis syndrome.[1,2] However, the latter term is not accurate as systemic calcification may affect internal organs such as the lungs, stomach, kidneys and adrenals.[3] Though the cause of calciphylaxis is multifactorial, sustained, relative or absolute, hypercalcaemia is thought to be the initiating facor.[3] In patients with calciphylaxis a Technetium (99mTc-MDP) radioisotope scan may show extensive increased activity throughout both lungs and lower extremities suggestive of hypercalcaemia or metastatic calcification. In the case described by Bataillard *et al (Clin Med* 2015;15:594–6),the corrected serum calcium is within normal limits but it may be artificially low because of the very low serum albumin (20 g/L). The patient was bed bound. I believe that the patient may have developed hypercalcaemia due to her prolonged immobilisation triggering the calciphylaxis. Immobilisation hypercalcaemia and hypercalciuria occur due to bone resorption and may respond to intravenous bisphosphonates.[4] However, more than 60% of cases with calciphylaxis have a fatal outcome.[3]■

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References

1 Selye H. *Calciphylaxis*. Chicago, IL: University of Chicago Press; 1962:1–100.
2 Dahl PR, Winkelman RK, Connolly SM. The vascular calcification-cutaneous necrosis syndrome. *J Am Acad Dermatol* 1995;33:53–8.
3 Essary LR, Wick MR. Cutaneous calciphylaxis: an underrecognized clinicopathologic entity. *Am J Clin Pathol* 2000;113:280–7.
4 Massagli TL, Cardenas DD. Immobilization hypercalcemia treatment with pamidronate disodium after spinal cord injury. *Arch Phys Med Rehabil* 1999;80:998–1000.

Response

We thank the correspondents for their interest in our case and comments. Our patient had been transferred to our care following a period in a rehabilitation ward which she had been admitted to following an unrelated inpatient hospital stay. It was during this time, when she was mobile (albeit not fully), that the ulcer originally developed. During this period she persistently had normal adjusted calcium and albumin levels (adjusted Ca^{2+} range, 2.14–2.40 mmol/L; albumin 36–39 g/L). When the ulcer failed to heal, progressed and became increasingly painful despite prolonged antibiotic courses, she then became immobile and was referred back to the acute hospital for further assessment. Importantly there was no prior history of primary hyperparathyroidism and at the time of admission, parathyroid hormone concentration was normal.

Serum ionized (free) calcium is maintained within a narrow range through parathyroid hormone secretion, which in turn is regulated by serum ionized calcium acting via calcium-sensing receptors on the surface of the parathyroid cells. Therefore normal parathyroid hormone levels would indicate that our patient was normocalcaemic even in her hypoalbuminaemic state. Although both immobility and hypoalbuminaemia can lead to an increase in ionized calcium, this would consequently lead to a reduction in parathyroid hormone secretion which was not the case. Thus, although her immobility may potentially have contributed to her overall condition, we did not feel that it was the trigger to the calciphylaxis.

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Sticks and stones: investigating rude, dismissive and aggressive communication between doctors

Editor – Bradley and colleagues make an important contribution to understanding the cultural issues that underpin patient safety in the NHS by describing the problem of rude, dismissive and aggressive (RDA) communication between doctors.[1] I would like to emphasise that this problem is not just confined to communications within hospitals but also across the primary–secondary care interface. As a general practitioner (GP) I have encountered RDA communication when trying to discuss patients with on-call hospital doctors. Often the tone of the conversation is patronising and not focused on solutions

but speciality bashing and trying to deflect admissions. This has a pernicious effect on morale and can affect the future behaviours of GPs who could be put off discussing difficult patients with certain specialities ('avoidant behaviour' as described in the paper) with a potential to affect patient safety.

I welcome recognition of this issue and attempts to define and codify it through research. I am sure this phenomenon occurs in other settings of care. As more and more interfaces are established between primary, community and hospital care, interactions between clinicians from different disciplines will become more common to support integrated care. To achieve a truly excellent patient-centred service, all clinicians must be aware of the issue of RDA communication and the destructive effect this can have on patient safety. The requirement for proper standards of professional communications must be emphasised to all doctors.■

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Reference

1 Bradley V, Liddle S, Shaw R *et al.* Sticks and stones: investigating rude, dismissive and aggressive communication between doctors. *Clin Med* 2015;15:541–5.

Response

We thank Mayur Lakhani for their comments with which we fully agree. Our study was confined to communication within teaching hospitals but rude, dismissive and aggressive (RDA) communication is also likely to occur in non-teaching hospitals and across the primary–secondary care interface.[1]

The ephemeral, impersonal nature of a phone call and the lack of a pre-existing relationship between clinicians are both risk factors for rudeness.[2] Individuals can reduce their risk of RDA communication by building relationships across primary and secondary care, but this is not a global solution.

There are few, if any, measurable outcomes currently available to detect or discourage rudeness and we agree research is needed to define, measure and report the extent of the problem. Recording phone calls 'for training purposes' may be an initial step towards this.

Departments may have poor organisational handling of referral activity, such as one doctor with a bleep who has multiple other duties. This promotes rudeness and the effects are worse in high intensity specialties. We agree that defining professional standards of communication and promoting respect are required steps but meaningful cultural change will not arise from a document alone and needs to be driven by leadership.[3] This will require persistent promotion by chief executives and other senior leaders if it is to have any impact. Jeremy Hunt has not set a good example of respect in communication.

References

1 Bradley V, Liddle S, Shaw R *et al.* Sticks and stones: investigating rude, dismissive and aggressive communication between doctors. *Clin Med* 2015;15:541–5.
2 Trumble S. The risk of rudeness. *Clin Teach* 2011;8:145–6.
3 Leape LL, Shore MF, Dienstag JL *et al.* Perspective: a culture of respect, part 2: creating a culture of respect. *Acad Med* 2012;87:853–8.

The Royal College of Physicians' Fallsafe care bundles applied trustwide: the Northumbria experience 2013

Editor – Richardson and colleagues should be applauded on widely implementing the RCP Fallsafe care bundles in Northumbria and for the large audit that was carried out.[1] They showed an improvement in compliance with the measures recorded before and after the introduction of the bundle. This mirrors the RCP Fallsafe project itself.

However, despite a slight decrease in falls, the number of falls per 1,000 bed days increased in this audit. This is an identical reflection of the RCP original assessment of the falls care bundle wherein there was an actual increase of 12% in falls after the introduction of the bundle. The reported falls per occupied bed days showed an increase consistently with and without harm in the acute and community settings but not in mental health.[2] The RCP document explained that was due to 'under-reporting' before the project and therefore calculated that rather than being harmful this was actually beneficial by correcting for likely under-reporting.

A reproduction of the RCP care bundle in Northumbria in fact shows an increased harm, ie an increase in the number of falls confirming what the initial RCP project showed ie an increase in the number of falls notwithstanding the calculation for under-reporting. Is it time to abandon the Fallsafe bundle and for the RCP to at least attempt a review if not a randomised controlled trial to finally clarify whether the bundle is harmful (as it appears at present on both the initial RCP data and the Northumbria experience) or beneficial? Our patients deserve better – in the case of falls, it seems masterly inactivity may be best, ie continuing current simple measures like blood pressure lying and standing checks, reviewing medication and encouraging therapists – without the cumbersome introduction of the comprehensive bundle with all the personnel and the paperwork associated with it.

Indeed, Richardson and colleagues aptly conclude at the end: Fallsafe advocates, falls teams, trust board members and clinical commissioning groups (CCGs) should be aware of possible confounding influences and limitations when setting possible target measures for inpatient fall reduction. These are wise words for CCGs.■

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References

1 Richardson DA, Bhagwat A, Forster K *et al.* The Royal College of Physicians' Fallsafe care bundles applied trustwide: the Northumbria experience 2013. *Clin Med* 2015;15:530–5.
2 The Health Foundation. *Closing the gap through clinical commissioning; the FallSafe project.* London: Health Foundation, 2012. Available online at www.health.org.uk/sites/default/files/CTGTCC-casestudiespdf [Accessed 12 February 2016].