

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

A cough that doesn't fit the mould

Editor – We read with interest the lesson of the month regarding invasive pulmonary aspergillosis in an immunocompetent patient.¹ We wish to highlight two points. First, the normal range (<40 mg/L) used for *Aspergillus* IgG was extrapolated from a study of 130 patient specimens, which was originally designed to compare the validity of an IgG assay against the standard double effusion test.² In order to investigate the utility of *Aspergillus* IgG levels in a clinical setting, we recently carried out a study of IgG levels in age-matched sera from two groups; a respiratory group with clinical suspicion of chronic pulmonary aspergillosis and a control group.³ A total of 696 IgG levels were available, 348 from each group. The arithmetic mean IgG titre was 37.4 mgA/L (\log_{10} ; 1.40) in the respiratory group and 22.4 mgA/L in the control group (\log_{10} ; 1.15) ($p < 0.0001$), although the group populations became aligned after accounting for quality assurance variation during the tests. We concluded that a significant overlap in levels does not allow the determination of a discriminatory cut-off value, and therefore interpretation of IgG should be used with caution.

Second, the authors stated that the duration of treatment would typically last at least 3 months. However, the duration of therapy has not been optimally defined.⁴ Three months of voriconazole would cost approximately £7,000⁵ per patient and long-term voriconazole may expose patients to unwanted side effects.

We hope that these two points highlight issues for consideration in the clinical setting of the diagnosis and treatment of suspected invasive pulmonary aspergillosis and we wondered to what extent long-term voriconazole is required following successful physiotherapy and mucus plug removal? ■

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Response

We thank the correspondents for their interest in our lesson of the month 'A cough that doesn't fit the mould'. The two points highlighted regarding the investigation and treatment of *Aspergillus* infection are important and highlight the difficulties in diagnosis and then optimal treatment of this infection.

We acknowledge the limitations of the cited normal range for *Aspergillus* IgG and would agree that this test should not be used in isolation to diagnose invasive Aspergillosis. As stated in our case and in the medical literature,¹ a combination of the clinical scenario, blood serologies (including *Aspergillus* IgG and IgE), radiology, sputum microscopy and culture and tissue biopsy should be used to form the diagnosis. We thank the correspondents for emphasising the important point that a diagnosis of invasive *Aspergillus* disease must be reached by such a synthesis of clinical information.

The correspondents' observations regarding the optimal treatment in this case are also important concerns. We agree that voriconazole should not be first-line therapy for clinical presentations such as that reported; our patient initially received physiotherapy and mucus plug removal via bronchoscopy. It was only after this failed to improve his symptoms that voriconazole was added and this, along with a second bronchoscopy resulted in resolution of his right lower lobe collapse.

As is observed, optimal management of cases such as this is uncertain given their rarity and the absence of robust medical literature. Management must be extrapolated from what evidence does exist. A randomised study of treatment for 3 months with voriconazole compared with amphotericin B for invasive aspergillosis resulted in fewer side effects and improved survival.² This trial was conducted in a group with significant immunocompromise following treatment for haematological malignancy. The study duration in this case, in addition to clinical practice in other areas of pulmonary aspergillosis, led to the decision to treat for 3 months. Such decisions must be made in the context of the clinical case. Further studies are needed both to determine the need for treatment and also whether shorter courses of therapy may be effective. ■

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Heart failure – what the general physician needs to know

Editor – The summary paper from the British Society for Heart Failure 7th meeting highlights some important aspects for the general physician with respect to heart failure management.¹ With respect to diagnosis, however, I would make one comment regarding the use of brain natriuretic peptide (BNP) and NT-proBNP in ruling out heart failure. While it is agreed that natriuretic peptide measurement is very helpful in ruling this out in the majority patients, it is important to bear in mind that in obese patients BNP and NT-proBNP levels are significantly reduced by mechanisms yet to be fully explained.² This raises questions about the utility of BNP and NT-proBNP in obese patients in heart failure; further studies are warranted here.

In the meantime, in obese patients where there remains a high clinical suspicion of heart failure, it is recommended that echocardiography is undertaken where the BNP or NT-proBNP level is normal, accepting the fact that echocardiographic views may be suboptimal in the context of an increased body mass index (BMI). Indeed, I have encountered several such cases of echocardiographic proven left ventricular systolic dysfunction in obese patients presenting with acute symptoms of heart failure and with normal NT-proBNP levels. Interestingly, our trust protocol suggests proceeding to echocardiography if clinically heart failure is still strongly suspected after a normal NT-proBNP level and the observations above would appear to support that approach. In an ever-increasing epidemic of increasing BMI in patients due to a variety of factors, it is likely this situation may become more frequent. ■

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Embedding comprehensive geriatric assessment in the emergency assessment unit: the impact of the COPE zone

Editor – I read with interest Taylor *et al*'s article in the February edition of *Clinical Medicine*, Embedding comprehensive geriatric assessment in the emergency assessment unit: the impact of the COPE zone (*Clin Med* 2016;16:19–24).

Their conclusion states 'services can be improved without major investment.' May I say that absolutely no assessment on the impact of community services, additional work for GPs, carer stresses, district nurse time or impact on social services was attempted? While Dr Taylor's trust did not have any major investment to deliver the new unit, what was the cost to the community services?

One geriatrician cannot run a service 365 days a year so there would be cost implications in this alone for their trust. Additionally, comprehensive geriatric assessment requires knowledgeable experienced staff in elderly care. To deliver such a team often means pulling them away from something else equally valuable within the trust.

We need to be careful not to throw the baby out with the bath water running to deliver a frailty friendly front door without robust research evidence. In my elderly care service we are trying to run six wards with six consultants – on three sites, 7 days a week, including orthogeriatrics and surgical referrals, as well internal holiday cover. We already have the highest number of inpatients patients per consultant.

More investment in elderly community services and hospital elderly care is required as well as innovative ways of working. Established hospital elderly care departments should not be put at risk to deliver fashionable trends based on blunt figures such as numbers discharged from the acute medical unit and hospital length of stay. These parameters are not surrogate markers for quality elderly care traditionally delivered within the hospital. ■

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Response

Editor – We thank the correspondent for their letter regarding our recent article *Embedding comprehensive geriatric assessment in the emergency assessment unit: the impact of the COPE zone*.¹ Care of frail older people admitted non-electively to hospital remains variable across the country, as highlighted in the recently published *Older people in the acute setting* NHS benchmarking report (available at www.nhsbenchmarking.nhs.uk/projects/network-projects.php#14). The COPE zone was developed from an established geriatrician in-reaching model. The job plans of pre-existing geriatricians and therapy staff were simply reconfigured, therefore the unit worked from the advantage of already having the team in post. Our data did not show any difference in observed outcomes for older people not admitted to the COPE zone, and the authors do not feel this service change led to any reduction in quality of service elsewhere. It is fair to say that there is a nationwide issue with financial constraints, workforce limitations and overworked staff as highlighted by the Royal College of Physicians special report *Hospitals on the edge? The time for*