Clinical Medicine 2017 Vol 17, No 6: 588–92

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

Referring wisely? or referring when you need help?

Editor – The Royal College of Physicians (RCP) has produced a report on inpatient referrals from generalist to specialist teams describing the presentations and conditions specialists feel ought to be referred, and conversely those which do not require this.[1] Inpatient referral is a neglected area and this report is to be welcomed in so far as it intends to start a conversation about the role of this activity.

Referrals within a hospital are a source of interpersonal conflict and can be met with an aggressive and obstructive response.[2] One reason for this is that meeting inpatient referral demand is low on department priorities. It is a largely unrecorded and often poorly resourced activity. If a clinician in the NHS spends the afternoon seeing five new patients in clinic this will generate >£1000 of department income, but seeing five new ward referrals is unlikely to generate any income.

It is regrettable that this survey was confined to being a supply-side enquiry, only asking the specialist providers of referrals for their view. Specialists are motivated to restrict their referral work to interesting and complex presentations but a generalist may require their help or advice on more prosaic matters. Whether or not a phone call for advice constitutes an 'inappropriate referral' depends very much on where you are sitting, rather than on the content of the question.

We don't yet know the end-point of the conversation that this report intends to start but it is at least possible that it will end with referral rationing. With that in mind it is premature for the authors to state that 'referring wisely benefits physicians and patients' as they commented in their associated statement (www.rcplondon.ac.uk/news/patients-and-physicians-benefit-referring-wisely). This assertion conflates the title of the report with the underlying activity. The RCP should avoid a descent into propaganda, even if the rest of the world is using newspeak. ■

BC WHITELAW
King's College Hospital NHS Foundation Trust, London
VH BRADLEY
Health Education Thames Valley, Oxford, UK

References

1 Royal College of Physicians. *Referring wisely*. London: Royal College of Physicians, 2017.
2 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

These comments from two recognised researchers in the area of medical referrals are helpful and it is good that the document is generating debate (which was its intention).

It is worth stressing that the report is aimed at all physicians and specialists in particular (not only generalists as implied by Drs Bradley and Whitelaw), given that it is the practice of multiple referrals to other specialty teams by a specialty team for advice on the management of common medical conditions that the RCP is seeking to develop the conversation on. The document is not intended to be a guide for generalists and should not be viewed in that light.

We have a shortage of consultants in almost all specialties, with only 55% of consultant posts being successfully appointed to in 2016. Most specialty teams are very hard pressed and we need to view the specialty 'consult' as a precious and limited resource that should be used wisely.

It should also be noted that this was not a survey. We worked closely with all the specialty societies to produce the document. The ethos of the document is one of collaboration and how we as physicians can ease unnecessary delays in all of our patients" care. We hope it will facilitate a refocusing on what it means to be a physician as well as a specialist and the positive engagement of all the specialties is to be welcomed.

It is arguable as to whether the publicity around the release of the document was propaganda. Propaganda is defined a message that helps a particular group or view – if patients are the group that benefit and the view we promote is improving collaboration between teams, is that a such terrible thing? ■

ANDREW GODDARD
Registrar
Royal College of Physicians

Medical problems in pregnancy

Editor – As a middle-grade doctor I found this article very useful.[1]

As commented by the authors, women are delaying childbirth until later in life.[1] Older women are more likely to have a medical disorder like hypertension, hyperlipidemia or diabetes mellitus, which are known risk factors for stroke.

Stroke in pregnancy has not been covered in this article; hence we are discussing this topic.

Stroke in pregnancy is relatively rare, but there is a three-fold increase in stroke incidence compared with non-pregnant women.[2] Acute stroke during pregnancy is a serious and stressful event, not only for the patient and family members but also for healthcare professionals.

The authors have rightly included cerebral venous sinus thrombosis, pre-eclampsia, eclampsia, and reversible vasoconstriction syndromes as the possible differential diagnosis of stroke in pregnancy.[1] Other causes of stroke are amniotic fluid embolism, postpartum angiopathy and postpartum cardiomyopathy.

In our experience the three common examinations that are not routinely performed are fundoscopy, blood pressure measurement in both arms and urine analysis for proteinuria.

MRI of the brain without contrast is the preferred imaging option in pregnancy. Time-of-flight MR angiography, which does not require contrast administration, can be used to evaluate the cerebral vasculature. CT brain may be performed if facility for MRI imaging is not available.[5]

Thrombolysis data are lacking as pregnant women were excluded from the clinical trials that validate rt-PA (recombinant tissue plasminogen-activator) in acute ischaemic stroke. Our knowledge about its use in this condition is based on case reports or case series.[3] Data from case studies has shown that thrombolysis is effective in ischemic strokes with a relative low risk to mother and foetus.[3]

Thrombolysis for ischaemic strokes should be considered after discussion with the obstetric team and the patient. The risks and benefits should be explained to the patient before administrating systemic thrombolysis. Thrombolytic therapy complications include pre-term labour, placental abruption, foetal death, post-partum haemorrhage and possible teratogenicity.[3] Acute stroke treatment decision-making is a complex process that must be performed quickly.[4]

With obstetric back-up, intravenous rt-PA should be administered followed by 'rescue' mechanical thrombectomy in situations where no clinical improvement is seen.[4]

In pregnant patients with malignant middle cerebral artery infarction syndrome and impending herniation, early decompressive craniotomy can reduce mortality and increase the likelihood of favourable outcome.

Haemorrhagic stroke also affects pregnant women. Non-contrast CT brain is the imaging modality of choice if SAH is suspected. Lumbar puncture to evaluate for xanthochromia can be useful if the CT shows no detectable subarachnoid blood, yet the suspicion for SAH is very high. Studies have suggested that surgical management of ruptured aneurysms during pregnancy is associated with significantly lower maternal and foetal mortality.

Last but not the least, there is a potential for medico-legal issues with all medical problems in pregnancy, hence the importance of clear documentation in medical notes of all discussions and the rationale for choosing a particular investigation or treatment. ■

Conflicts of interest

The authors have no conflict of interest to declare.

RITESH SAH
Locum registrar in Stroke Medicine, Russells Hall Hospital, Dudley, West Midlands, UK

SHAHID A KAUSAR
Consultant in Stroke, Geriatrics and General (Internal) Medicine, Russells Hall Hospital, Dudley, West Midlands, UK

References

1 Narayan B, Nelson-Piercy C. Medical problems in pregnancy. *Clin Med* 2017;17:251–7.
2 Treadwell SD, Thanvi B, Robinson TG. Stroke in pregnancy and the puerperium. *Postgrad Med J* 2008;84:238–45.
3 Tassi R, Acampa M, Giovanna M *et al.* Systemic thrombolysis for stroke in pregnancy. *Am J Emerg Med* 2013;31:448.
4 Demchuk A. Yes, intravenous thrombolysis should be administered in pregnancy when other clinical and imaging factors are favorable. *Stroke* 2013:44:864–5.
5 Grear KE, Bushnell CD. Stroke and pregnancy: clinical presentation, evaluation, treatment and epidemiology. *Clin Obstet Gynecol* 2013;56:350–59.

Editor – We were interested to read the article by Bhaskar Narayan and Catherine Nelson-Piercy, 'Medical problems in pregnancy'.[1] However, in the neurology section we felt that a couple of important safety issues were not addressed clearly enough.

For headache, from an investigation point of view, we have noticed on ward referrals that fundoscopy may be omitted. This is particularly useful in this group given sinus thrombosis is high on the list of differentials.

Additionally, migraine treatment is complex and aspirin is useful, but it should not be used in the third trimester because of its impact on closure of the ductus arteriosus, as noted in the British national Formulary (BNF) as well as elsewhere.[2]

Likewise, propranolol is listed as causing intrauterine growth restriction in the British National Formulary – 'Beta-blockers may cause intra-uterine growth restriction, neonatal hypoglycaemia, and bradycardia; the risk is greater in severe hypertension' – and www.drugs.com also warns that 'this drug is only recommended for use during pregnancy when there are no alternatives and the benefit outweighs the risk' and 'beta blockers may cause decreased placental perfusion, fetal and neonatal bradycardia, and hypoglycemia'.

Furthermore, NICE guidelines counsel against opiates for migraine because they are ineffective – 'Do not offer ergots or opioids for the acute treatment of migraine'.[3]

Topiramate and valproate are both licensed for migraine treatment but should not be offered to pregnant patient as they are teratogenic.

Epilepsy in pregnancy is another complex issue as described; lamotrigine, carbamazepine and levetiracetam account for over 80% of AEDs used in pregnancy. Phenytoin has been falling in use, with less than 2% of women with epilepsy on the register in 2006 using it. With regard to lamotrigine, the commonest drug used, it is known that levels tend to fall in the third trimester; the findings on the register show that some authorities tend to obtain a single drug level early in pregnancy in controlled patients only reassessing this if there is loss of seizure control, rather than monitoring throughout. ■

IRINA STOIAN
Clinical fellow in Neurorehabilitation and Neurology, St George's Hospital, London

BRIDGET MACDONALD
Consultant neurologist, St George's Hospital, London