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Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within 3 weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

Medical problems in pregnancy

Editor – We were disappointed that the letter by Stoian and MacDonald (*Clinical Medicine*, December 2017) in response to our article[1] makes some incorrect statements about medications in pregnancy.

Low-dose aspirin has extensive safety data in pregnancy, including the third trimester. A recent multi centre double-blind placebo-controlled trial found that aspirin 150 mg daily taken until 36 weeks gestation did not have any adverse effects on the foetus or neonate.[2] Given that the suggested dose for migraine prophylaxis is only 75 mg, we can confidently regard it as safe. The British National Formulary (BNF) may advise caution, but this is based on the much higher anti-inflammatory dose of aspirin. The authors of the letter should note that the mechanism and effects of low-dose aspirin are rather different than that of high-dose aspirin.

With regard to propranolol, there have historically been concerns about the effects of *in utero* exposure to β-blockers on foetal growth. However, this was observed in hypertensive mothers, so it is difficult to clearly distinguish the role of the drug versus maternal disease. Furthermore, the association was seen when using significantly higher doses than those suggested for migraine prophylaxis. Low-dose propranolol is now well recognised as an acceptable second-line option for migraine prophylaxis in pregnancy.[3–6]

In the treatment of acute migraine attacks, we agree that the use of opiates should be avoided, and this is stated in the original article. Finally, we agree that fundoscopy can be useful in the clinical assessment of any patient presenting with headache. The loss of spontaneous venous pulsation is a subtle sign of raised intracranial pressure. However, we would emphasise that normal fundoscopy does not exclude serious intracranial pathology. ■

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Screening for obstructive sleep apnoea using the STOPBANG questionnaire

Editor – We read with interest the report by Isaac *et al*.[1] in which they screened for obstructive sleep apnoea (OSA) in acute medical take patients, in particular their use of the STOPBANG questionnaire.[2] We also have experience using this instrument, in the context of a cognitive disorders clinic based in a neurology centre,[3] because of the possible contribution of OSA to symptoms of cognitive impairment.[4]

Our cohort of consecutive patients referred over a 3-month period with unexplained memory symptoms (n=67) was somewhat younger than that of Isaac *et al* (≤50 years of age: 12/67 = 18% vs 31/93 = 33%) and with a male preponderance (61% vs 43%). Nevertheless, using the STOPBANG score ≥3/8, the criterion for 'suspected high risk of OSA', around half of our patients screened positive (33/67 = 49% vs 73% in Isaac *et al*).

Evidently, STOPBANG is a highly sensitive test and therefore likely to detect prevalent cases of OSA, but in addition it will also identify large numbers of false positives; examination of the item content of STOPBANG shows that any tired male over 50 years of age will screen positive, ie score ≥3/8. Hence, as a stand-alone screen on which to base decisions about onward referral to services dedicated to diagnosis and treatment of OSA, use of STOPBANG might well prove overwhelming.[3] We therefore endorse the idea of using a second screener, such as the Epworth sleepiness score (ESS), prior to initiating onward referral to OSA services in order to try to reduce the false positive rate. ■

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