

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 article¹ 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 $\geq 3/8$, 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 $\geq 3/8$. 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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Thoracic ultrasound experiences among respiratory specialty trainees in the UK

There were some interesting points raised by Sivakumar *et al* in their article on thoracic ultrasound experience among respiratory trainees in the UK.¹ The difficulties with supervision and competent senior clinicians is one which is also seen among acute internal medicine trainees wishing to gain experience in point of care ultrasound (POCUS),² and requires much work to overcome. It is reassuring that progress is being made within respiratory medicine.

The fact that a number of trainees claim confidence in diagnosing pulmonary oedema and pneumothorax with ultrasound is interesting, since neither of these pathologies are covered within the Royal College of Radiologists (RCR) curriculum.³ Indeed, I am not aware either of a training curriculum that sits within respiratory medicine which covers the use of bedside ultrasound for respiratory failure, as opposed to pleural disease which has traditionally been the mainstay of thoracic ultrasound. To my knowledge, the focused acute medicine ultrasound (FAMUS) curriculum⁴ is the only training programme for physicians within the UK which covers the use of POCUS in patients with conditions like pneumothorax and pulmonary oedema.

I agree with the sentiment that the current RCR curricular do not entirely fulfil the requirements of respiratory medicine trainees, since they do not cover the use of thoracic ultrasound for respiratory failure. There is increasing evidence for the utility of POCUS for aiding diagnoses of pneumothorax, pulmonary oedema, pneumonia, asthma/COPD and pulmonary embolism,⁵ and this should surely form part of a future respiratory medicine ultrasound curriculum. This seems imperative to me given that respiratory medicine (and indeed acute internal medicine) care for the majority of medical patients with acute respiratory failure.

A revision of the current respiratory medicine ultrasound curriculum to include a respiratory failure component would require a significant undertaking from training committees to support both trainees to achieve those competencies, and trainers to deliver them. However, given this is a largely untapped use of POCUS with significant scope to improve diagnostic accuracy,⁵ it is a logical extension of the current use of ultrasound within respiratory medicine. ■

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Conflict of interest

The author is a member of the FAMUS working group.

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Sleep in adolescents and young adults

Editor – I congratulate the authors of the recent article about sleep in adolescents and young adults (AYAs).¹ Like the authors, I am aware of the association between poor sleep hygiene and the development of mental health and chronic pain disorders. As a consultant physician working in the UK with an interest in AYA care, I observe the consequences of poor sleep in this group of patients on an almost daily basis. I have an interest in ‘smartphone overuse syndrome’ (SOS) in AYAs and, in particular, smartphone use at night and the negative effects it may have on sleep. The UK Ofcom communications report published in 2016 highlighted that, on average, we now spend more time on electronic media and communications than we do sleeping.² Two-thirds of 16–19-year-olds wake in the middle of the night to check their phones.³

A number of theories have been proposed about how smartphone use in the evening and at bedtime can affect our sleep.⁴

- > Sleep could simply be displaced by smartphone use at night leaving less time for sleep, sometimes referred to as ‘sleep stealing’.
- > Smartphone use at bedtime could lead to increased mental, emotional or physiological arousal and therefore interfere with time to onset of sleep.
- > Light emission from smartphones that use back-light or ‘blue-range’ light technology has been demonstrated to interfere with melatonin secretion and our circadian physiology.
- > Incoming messages, emails, status updates or calls can disturb sleep and are associated with a reduction in the quantity and quality of deep or ‘restorative’ sleep.

The comorbidity of depression with sleep problems is common and well documented.⁵ A recent meta-analysis reviewing the relationship between sleep and depression in adolescents suggested that sleep disturbance plays a key role in the aetiology of depression during adolescence.⁶ A study published in 2012 found a significant association between nocturnal mobile phone use and poor mental health, suicidal feelings and self-harm after controlling for other confounding variables (including sleep length) in 17,920 adolescents.⁷

Despite evidence demonstrating an increase in the use of electronic media and smartphones in AYAs, as well as evidence linking this increased use to sleep and mood disturbances, studies looking at smartphone use, sleep disturbance and chronic pain