

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

Spontaneous resolution of frontotemporal brain sagging syndrome

Editor – Like Dr Kent and colleagues,¹ I have recently seen a patient with apparently spontaneous resolution of neuroradiological features of frontotemporal brain sagging syndrome (FTBSS), but with different clinical outcome.

A previously healthy 70-year-old man was referred from primary care with memory symptoms and headaches, the latter worse in the mornings. Family members reported forgetfulness over about 12 months, mixing up people's names and sometimes repeating himself. He had developed low mood, not helped with antidepressant medications.

On neurological examination, there was psychomotor retardation, and the head turning and applause signs were evident,² but no other features. On the Mini-Addenbrooke's Cognitive Examination he scored 10/30 (attention 2/4, memory 4/7, letter fluency 2/7, clock drawing 0/5, memory recall 2/7), and on Free-Cog 12/30 (cognitive function 8/25, executive function 4/5).

Magnetic resonance (MR) brain imaging, performed prior to neurology referral, showed normal brain parenchyma aside from minor small vessel ischaemic changes, but bilateral shallow subdural collections, slight inferior displacement of the brainstem, and uniform meningeal enhancement on contrast imaging, suggestive of low cerebrospinal fluid (CSF) pressure. A presumptive diagnosis of FTBSS was made. Subsequent MR spinal imaging revealed no CSF leak.

Blind blood patching was planned, but deferred when at 3-month follow-up both the patient and his family reported improvement in cognitive function. However, at 6-month follow-up the patient's clinical state had deteriorated, with reduced speech output and personality change with uncharacteristic outbursts of anger. Repeat MR imaging, 10 months after the initial study, showed complete resolution of both subdural collections and meningeal enhancement. There was evidence for right temporal lobe atrophy. A presumptive diagnosis of frontotemporal dementia was made.

The exact relationship of the neuroradiological signs of low pressure and the clinical features was uncertain in this patient. Resolution of the former with progression of the latter suggests that in this case they were incidental. Clinicians should keep an open mind on the cause of cognitive symptoms in the presence of neuroradiological signs of low CSF pressure. Based on experience of this case, I suggest continued follow-up of patients with spontaneous resolution of FTBSS is indicated. ■

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Head injury in the elderly

Editor – We welcome the excellent review of head injury in the elderly¹ in a recent edition of your journal. The important point is made that head injury often occurs from a standing height in older adults, however so too does cervical spine fracture.² Indeed, the Canadian C-spine rules deem those at 'high risk' from a fracture to be those over the age of 65, those with extremity paraesthesia, or sustaining a dangerous mechanism of injury (fall from greater than three feet, axial load injury, road traffic accident, bicycle collision). According to this rule, the cervical spine cannot be clinically cleared if the patient fits any of the above criteria and imaging is recommended.³ Our local experience from a recent audit is that only 17% of patients over the age of 65 receiving a computed tomography head for a traumatic indication have their cervical spine imaged as well. A national audit of major trauma management in older people showed that current triage is not optimal for older people as they often get reviewed by more junior doctors than their younger counterparts.⁴ The advanced trauma life support (ATLS) guideline acknowledges that 'airway' always comes first but with the important adjunct of cervical spine protection.⁵ In our opinion, reference to the importance of cervical spine assessment in the management of head injury in older patients will lead to more appropriate and comprehensive imaging in a timely fashion thereby improving the outcome in these vulnerable patients. ■

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- 4 Banerjee J, Baxter M, Coats T *et al*. *Major trauma in older people*. Salford: The Trauma Audit And Research Network, 2017. www.tarn.ac.uk/Content.aspx?c=3793 [Accessed 20 June 2019].
- 5 The Royal College of Surgeons of England. *Advanced Trauma Life Support® (ATLS®)*. London: RCS.

Reducing demand for computed tomography

Editor – I was interested in the article by Lewis *et al* in July on a nudge intervention aimed at reducing demand for computed tomography (CT).¹ While impressed with the reduction in CT requests, I was surprised by their decision to place the intervention (a message highlighting the radiation risk from the scan) in the report of scans, rather than earlier in the process of ordering a scan. In their discussion they state that ‘This approach was preferred to the alternative of delivering the information at the time of deciding to do the scan when it could impact on the efficient delivery of clinical care’. Their subsequent argument that it is difficult to go back to a patient and explain why CT may not be necessary is not entirely convincing.

As most radiology tests in the UK are now ordered electronically, computer physician order entry (CPOE) systems have the ability to display messages during the process of ordering a test. There is also the potential for CPOE systems to calculate individual risk (and display different messages) depending for example on the age of the patient or the number of previous CT they have undergone. It would be interesting to know whether such a system might have an even greater impact in reducing CT ordered, and particularly in younger patients who are at greater risk of cancer from ionising radiation. ■

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The curriculum in general internal medicine

Editor – I note with interest that the current Joint Royal Colleges of Physicians Training Board curriculum in general internal medicine (GIM) is currently being reviewed and consideration is being given to current procedural competencies that are required from GIM registrars.¹

Currently, trainees must be able to perform abdominal paracentesis, direct current cardioversion and knee aspiration independently. Clinical independence is desirable for central venous cannulation (CVC) and intercostal drain (ICD) insertion for pneumothorax and pleural effusion. Under particular scrutiny will be CVC and ICD insertion and indeed a recent social media discussion from the Royal College of Physicians Trainees Committee generated much discussion surrounding these skills.

There is much regional variation in the frequency GIM trainees perform these procedures and the necessity that a GIM trainee would have to perform them in their local hospitals and deaneries. Some areas require medical trainees to perform both on a regular basis and they would often carry out these procedures for their own patients. Other hospitals have out-of-hours respiratory teams and CVC insertion is supported by anaesthetic and critical care colleagues. The requirement of pleural ultrasound for the insertion of intercostal drains for fluid, as described the British Thoracic Society,² further complicates matters. Training in both of these procedures varies and, to my knowledge, no formal training pathway for general medicine registrars exists. Concerns also exist over how ongoing competency should be reviewed and assessed for trainees who may perform these procedures less frequently or not at all.

Internal medicine training replaces core medical training this year.³ Junior medical trainees are now required to rotate through critical care. This could address some of the training, competency and confidence concerns regarding central venous cannulation early in medical trainees’ careers. Bedside ultrasound in medicine and its increasing popularity, alongside formalisation of its training (for example, focused acute medicine ultrasound),⁴ will also help. Ultimately, any curriculum change should reflect the requirements of both patients and trainees up and down the country and consideration should not only be given to these varying requirements, but to how trainees can easily acquire and maintain competency in these skills. ■

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- 4 The Society for Acute Medicine. *Focused acute medicine ultrasound (FAMUS)*. Curriculum pack. Edinburgh: SAM, 2019. www.acutemedicine.org.uk/wp-content/uploads/2019/06/FAMUS-curriculum-pack-v2.0.pdf.

Dementia with Lewy bodies

Editor – I read with interest the ‘Acute presentation of dementia with Lewy bodies’ by Akintade and Pierres in the July edition of