

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

VTE prophylaxis for medical patients when they leave hospital: a wider approach to future research and evidence is required

Editor – *Clinical Medicine* has published a summary of the National Institute for Health and Care Excellence (NICE) NG89 recommendations on venous thromboembolism (VTE) prophylaxis.^{1,2} Subsequently the guidance for pharmacological prophylaxis for a minimum of 7 days for medical inpatients who are at high risk has been challenged by haematologists both for effectiveness and cost effectiveness when the patient has been discharged before this course length has been completed.^{3,4} In the last edition of *Clinical Medicine*, Thomas *et al* estimated the drug related costs of this aspect of the guidance for patients who would require ongoing prophylaxis post discharge, but they were unable to estimate the cost for district nursing support for those who could not self administer.⁵

The Royal College of Physicians' Patient Safety Committee considered the implications of this element of the guidance in 2018 and concluded that the level of evidence was unclear and that implementation of the guidance across medical practice currently in the NHS did not include continuation of pharmacological prophylaxis post discharge. This was communicated to NICE. Given reducing lengths of stay in hospital, increasing community support

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for patients who are immobilised during acute illness, we believe that 'hospitalisation' as a marker of risk for VTE in acute medical illness is a rather blunt risk factor. Future research should consider the patients risk overall, at home or in hospital. Cost effectiveness of pharmacological intervention must include support care costs for patients who are unable to manage this therapy and the risks of polypharmacy in this cohort. ■

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Newer rehabilitation therapies: strategies in chikungunya chronic arthralgia

Editor – Pathak *et al* looked over epidemiology, immunopathogenesis and management of chikungunya arthritis and reported several medication treatments in acute and chronic phase, however there is no discussion of physical rehabilitation.^{1,2}

Since chikungunya could be considered as a neglected tropical disease, potentially affecting over 1 billion people, additional supportive managements should also be investigated to establish more strategies to prevent arthralgia and increase functionality.^{3–5} As in other rheumatic diseases, the recommended managements for chikungunya aim to prevent disability, unproductive work and secondary manifestations.^{6–8} The chronic chikungunya arthralgia/arthritis symptoms suggests an immune mechanism to medication treatments, however the growing scientific evidences of physical rehabilitation improving functionality and quality of life should be more explored at the managements.⁶ The World Health Organization and several societies of rheumatology recommend rehabilitation interventions in all phases of chikungunya, and include exercises, stretching, manual therapy and aquatic physical therapy.^{9,10} Moreover, two recent trials suggest novel approaches of rehabilitation therapies with transcranial direct current stimulation and pilates to reduce pain and improve functionality.^{4,11} The long-term burden of persistent arthralgia negatively impacts the public health system, economically active people and quality of life.¹⁰

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Therefore, the association between pharmacological and physical rehabilitation could enhance the chikungunya management efficiency, decreasing chronic pain symptoms and treatment abandonment. Scientific evidence of several healthcare fields should support the development of a more complete chikungunya guideline to properly adjust to the individual patient needs, causing significant changes to their quality of life and general functionality. ■

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Misdiagnosing Bell's palsy as acute stroke

Editor – Induruwa *et al* describe the difficulties in diagnosing Bell's palsy in their secondary care setting.¹ Only 40% of doctors documented other important non-stroke like symptoms; none documented changes in taste or lacrimation, key attributes of facial nerve lesion; from initial clerking, only nine patients received steroids before further investigation or specialist review; 31/46

received no treatment after initial clerking. They point out that Bell's palsy can be difficult to diagnose and differentiate from acute stroke and they describe the adverse consequences of delays in diagnosis and in initiating treatment. They suggest that there is a lack of confidence in diagnosing Bell's palsy both in primary and secondary care, and feel that resources could be saved if it could be diagnosed and managed in primary care. From their findings I would conclude the opposite. Such cases should be assessed in secondary care with access to a specialist so that timely correct treatment and follow-up can be instituted. The idea that all this can be undertaken by overworked and undertrained general practitioners is both unrealistic and bad for patient care. ■

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- 1 Induruwa I, Holland N, Gregory R, Khadjooi K. The impact of misdiagnosing Bell's palsy as acute stroke. *Clin Med* 2019;19:494–8

Response

The basis of our paper is to increase awareness of atypical features which should prompt a referral to secondary care, and typical features of Bell's palsy which should reassure the attending physician – whether in primary or secondary care. The paper does not target a particular cohort of doctors, rather it aims to empower physicians with the knowledge to make an accurate and confident diagnosis, highlights the importance of early treatment, and the need to utilise further resources for patients with red flag signs suggestive of other diagnoses such as acute stroke. ■

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