Letters to the editor

OVERVIEW

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Austrian syndrome

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Editor – thank you for publishing the article about Austrian syndrome.[1]

There is just one thing I would like to mention; the article ends with 'We also propose that this syndrome should be renamed as Osler's syndrome with Osler's tetrad, in acknowledgement that Sir William Osler was the first to describe the triad of pneumonia, meningitis and endocarditis with presence of 'micrococci' in affected tissues and blood.'

I am aware that there is a language barrier as some really old articles are in German, but it is not the full truth that Osler was the first; Mandal *et al*'s article does not mention Richard Heschl at all. Heschl described a case series of patients with endocarditis, pneumonia and meningitis in 1862.[2] If we take the historical background into account, and the fact that there was no 'bacteriology' in the 1860s (eg Ferdinand Julis Cohn published 'Untersuchungen über Bakterien' in 1872, Robert Koch described *Bacillus anthracis* in 1876), Heschl was as close to the pathophysiology as he could have been in the early 1860s.

I would like to propose another approach, if we have to rename the syndrome (do we have to?), then to name it Heschl syndrome, or do as with all the other syndromes and get rid of the eponymous names and call the pathophysiology something like 'Pneumococcal multiorgan infestation syndrome affecting heart, lung and central nervous system' as a (very long – apologies) description for the syndrome. ■

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Perioperative diabetes management in patients with kidney disease

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Editor – We read with interest the article 'Perioperative diabetes care' by Ketan Dhatariya and Nicholas Levy.[1]

We wanted to highlight the challenges involved in management of diabetic patients with chronic kidney disease (CKD), acute kidney injury (AKI) and AKI on CKD. We believe that it is important to note the role CKD and AKI play in the management of patients with diabetes. There is a well-known association between diabetes and development of CKD. Mathew *et al* found that CKD was an independent risk factor for postoperative morbidity and mortality, with a strength of association similar to that of diabetes, stroke or coronary disease.[2]

The risk of side effects of some antidiabetic medications, such as metformin and thiazolidinediones, increases in patients with CKD. Zanchi *et al* have concluded that only sitagliptin, saxagliptin and linagliptin may be used in advanced kidney disease, while GLP-1 agonists are contraindicated.[3]

Furthermore, there are multiple mechanisms by which surgery can lead to the development of AKI, especially in patients with a known history of CKD. The use of non-steroidal anti-inflammatory drugs for pain management, contrast-media for imaging studies and volume depletion during surgery are all contributing factors. Hobson *et al* recommend using different predictive strategies, including scoring systems and clinical judgement to determine the risk of AKI in patients undergoing surgery.[4] Some hospitalised patients are on anticoagulants for various reasons. Anticoagulation-related nephropathy is a significant but underdiagnosed complication of anticoagulant treatment. It is most commonly associated with warfarin but some studies suggest its association with novel anticoagulants as well.[5]

There is a known strong association between type 2 diabetes and atrial fibrillation, increasing the likelihood that the patients have been prescribed anticoagulants. We therefore believe that more detailed guidelines are needed to determine the best approach to perioperative management of patients with diabetes and comorbid kidney disease, including finding the best AKI prevention strategies, reducing the risk of medication side effects, finding the optimal anticoagulation regimen and ensuring long-term renal protection. ■

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Making every contact count: the role of the clinician in smoking cessation during the perioperative period

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Editor – We read the paper by Durrand *et al* about setting up prehabilitation services with interest and would like to highlight our learning and insight from a local smoking cessation service for perioperative patients.[1]

Smoking is an independent predictor of postoperative complications, and modifications have shown to improve outcomes after surgery.[2] The perioperative period can be an auspicious time to address risk-taking behaviours, like smoking, as patients may be more receptive to making positive changes that can impact their health.[1] Clinicians can play an important role in patient behavioural change by using strategies like Making Every Contact Count (MECC).[1,3]

Smoking has been recognised as the main cause of preventable illness and premature mortality in England and is associated with increased perioperative risk and delayed postoperative recovery.[4,5] Smoking cessation advice and referral has been shown to be cost effective in helping people quit and is an intervention that lends itself well to MECC.[6] Clinicians who are involved in perioperative care can be key personnel in delivering lifestyle advice and referring patients to smoking cessation services.

Yet despite these health risks, nationally there has been a decline in using smoking cessation services and prescriptions for nicotine replacement therapy.[4] In our hospital trust, we found that of 122 patients reviewed in preoperative clinic, 21% (26), were identified as smokers. Of those patients, 65% (17/26) were offered a referral to smoking cessation services of which 76% (13/17) declined. With a 59% attendance rate following acceptance of referral, only 8% (2/26) of smokers seen prior to surgery engaged with smoking cessation services. Some of the barriers to successful referral encountered were lack of behavioural modification training among staff and a significant proportion of patients declining referral when given the option of attending.

The National Institute for Health and Care Excellence recommends that patients who smoke and are planning to have surgery should be referred directly to smoking cessation support services. This opt-out model should be part of routine care and staff should be equipped with the skills to deliver this service.[6] Hence, we suggest training in MECC and behavioural modification should be incorporated into postgraduate medical and nursing training. ■

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Trends in recruitment into core medical training in the UK – could doing quality improvement projects help?

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Editor – Butterworth and colleagues highlight the problems of recruiting and retaining enough medical trainees.[1] They also mention there is a similar crisis in general practice. As medical students who were recently encouraged to become general practitioners (GPs) by conducting quality improvement projects in primary care, we would like to share what we learned. We hope it might be of interest to medical specialties.

To start with, we looked at a range of audits that might be useful to the practice and chose topics based on personal interest. We found it exciting for us as students to have the possibility of influencing clinical practice and improving patient care. This made our projects more enjoyable in terms of academic learning.

We found general practice was a friendly and supportive environment for carrying out an audit. Learning how to create our own databases and doing simple statistical analysis made us feel more confident about carrying out future audits exploring the gaps between guidelines and practice.

We discovered a common theme in our audits – the tension between adhering to national guidelines and feasibility in busy, everyday practice. An example of this was one of our audits looking at whether GPs comply with National Institute for Health and Care Excellence guidelines to screen patients with