

letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to:
Clinicalmedicine@rcplondon.ac.uk.

Medical Records and their Recordors

Editor – Your editorial (*Clin Med*, July/August 2003 pp 301–2) and the article by Mann and Williams¹ are timely. To a bacteriologist who many times had to analyse series of patients' notes the varieties or even absence of structure was an unnecessary burden. But who does the recording also matters. Over 50 years ago as a house physician puzzling over a patient, I referred to his notes from an admission twenty years earlier. They were beautifully and intelligently written. Their student author was Janet Vaughan, by then a distinguished haematologist.

As you say, chronic patients' records are particularly difficult. In the Rheumatic Unit at the Canadian Red Cross Memorial Hospital, Taplow, children with Still's disease remained in hospital for many months. Generally this would have meant an unwieldy mass of notes which, even if legible, needed weary searching for whatever nuggets they might contain. At Taplow the notes, rigidly controlled by Eric Bywaters, the unit director, consisted of semi-formalised information on a series of charts sellotaped into a long horizontal scroll. The senior registrar's job was to impose the Bywaters doctrine onto the daily practice of a series of house physicians. But finding data and following a patient's course was quick and easy.

More recently, when involved in an intensive surveillance of hospital-acquired infection,² I hoped that computerisation of notes would help. It did, but not much since every hospital had a different system. As Mann and Williams suggest, there is still

a long way to go. Developing good systems is difficult but whether records are computerised or not, the following quotation³ (from memory) applies,

'Easy reading's curst hard writing' –
Editors *Journal of General Microbiology*

'Easy writing's curst hard reading' –
Richard Brinsley Sheridan

References

- 1 Mann R, Williams J. Standards in medical record-keeping. *Clin Med* 2003; 3:329–32.
- 2 Glynn AA, Ward Valerie, Wilson J, Charlett A et al. Hospital-Acquired Infection: Surveillance Policies and Practice. London, Public Health Laboratory Service, 1997 pp7 and 71.
- 3 Quotation printed on the cover of the *Journal of General Microbiology* for many years.

PROFESSOR ALAN GLYNN
Former Director of the Central Public Health
Reference Laboratory of the PHLS (1980–1988)
Colindale

Editor – Belated congratulations to the authors of the paper on standards in medical record keeping (*Clin Med*, July/August 2003 pp 329–32) for highlighting a professional issue of fundamental importance.

After this, the fiction will no longer be a sustainable one that composing a clinic letter or a discharge summary is a mindless chore, and that neither of these two activities makes a contribution towards continuing professional development.

OMP JOLOBE
Retired Geriatrician

Investigating older people

Editor – Deciding when, whether and how far to investigate older people is becoming increasingly complex in the face of wide armamentarium of investigations available to modern day clinicians. In geriatric practice, we face this dilemma often. In this respect, the article by BJ Adler and DJ Stott (*Clin Med*, September/October 2003 pp 418–22) on how far to investigate to older people is helpful and thought provoking.

We have two concerns. Firstly, we question the usefulness of an algorithm in dealing with this complex problem.

Secondly, the algorithm appears to suggest that in patients not competent to consent to investigations, the clinical responsibility is transferred from the medical team to the next of kin. We agree that next of kin should be consulted and their views taken into account. However, we do not believe in withholding necessary investigations solely on the basis of disagreement with the next of kin. In such cases, the option of obtaining an independent second medical opinion may be useful.

R SIVAKUMAR
Specialist Registrar

T TONG
Consultant Physician

Lister Hospital
Stevenage

In response

We thank Drs Sivakumar and Tong for their interest in our article.

The algorithm that we provide is intended to emphasise key principles that may affect decision-making for investigation of older patients. We hope that it will reinforce the importance of careful selection of investigations in older patients with multiple pathology, the necessity of determining competency of patients to give consent for investigation, and the importance of discussing plans for investigation with next of kin or guardian if a patient is not competent to give consent. Neither in the algorithm nor in the text of the article do we suggest that clinical responsibility should be 'transferred' from the medical team to the next of kin. It is however imperative that their views be sought and taken into account in making any decision

about investigation (this applies particularly to invasive procedures). Often the next-of-kin will have insights as to what the patient's views were when still competent. In Scotland this process of consultation was enshrined in law in 2000 with the Adults with Incapacity Act.

B J ADLER
Senior House Officer

DAVID J STOTT
Professor of Geriatric Medicine
Academic Section of Geriatric Medicine
Glasgow Royal Infirmary

Editor – Melanie Davies' review of the prevention of diabetes (*Clin Med* September/October 2003, pp 470–4) is comprehensive but lacking in one important aspect, specifically the influence of sleep disruption on metabolism. This has been the subject of peer-reviewed research from two perspectives:

- 1) The association of impaired glucose tolerance (IGT) with obstructive sleep apnoea (OSA). Ip *et al*¹ reported IGT directly proportional to the severity of OSA, and which is reversed by treatment of the apnoea by nasal positive airway pressure.² At the same time, Punjabi *et al*³ reported in mildly obese individuals insulin resistance again proportional to sleep disordered breathing.
- 2) The impact of sleep debt on glucose metabolism. Van Cauter⁴ has reported the development of IGT in previously healthy subjects submitted to seven days of sleep restriction (of four hours per day). Assessment of heart rate variability in this study suggested an increase in sympathetic tone, and this as the mechanism for IGT. A similar mechanism is proposed in OSA where urinary excretion of catecholamines is increased, which can be reversed by treatment of the OSA with nasal CPAP.

Sleep restriction, albeit not to the extent of Van Cauter's study, is ubiquitous in our modern society. Similarly, sleep apnoea is very common with 24% of men aged 30–60 having more than five apnoeas per hour of sleep, and with hypertension now accepted as a direct adrenergic consequence of OSA.⁵

Clearly, inactivity and diet are critical to

the development of obesity but if IGT can result from insufficient or interrupted sleep, and IGT promotes increase in weight which in turn worsens sleep apnoea and IGT, it has not escaped this sleep physician's notice that the epidemic of diabetes and of obesity may have a common denominator.

References

- 1 Ip MS, Lan B, Ng MM, Lan WK *et al*. Obstructive sleep apnoea is independently associated with insulin resistance. *Am J Respir Crit Care Med* 2002;165:670–6.
- 2 Harsch IA, Pour Schahin S, Radespiel-Troger M *et al*. CPAP treatment rapidly improves insulin sensitivity in patients with OSAS. *Am J Respir Crit Care Med* 2003; Oct 2 (Epub ahead of print).
- 3 Punjabi NM, Sorkin JD, Katzel LI, Gudberg AP *et al*. Sleep Disordered breathing and insulin resistance in middle aged and overweight men. *Am Rev Respir Crit Care Med* 2002;165:677–82.
- 4 Spiegel K, Leproult R, Van Cauter E. Impact of sleep debt on metabolic and endocrine function. *Lancet* 1999;354:1435–9.
- 5 Peppard PE, Young T, Palta M, Skatrud J. Prospective study of the association between sleep-disorders breathing and hypertension. *N Engl J Med* 2000;342:1378–84.

ADRIAN WILLIAMS
Consultant Physician and Director
Lane-Fox Respiratory Unit and Sleep Disorders
Centre
St Thomas' Hospital

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Is prolonged use of computer games a risk factor for deep venous thrombosis in children?

Case Study

Deep venous thrombosis (DVT) rarely occurs in children.^{1–2} Its occurrence usually suggests an inherited or acquired hypercoagulable state. Mechanical obstruction and prolonged immobility such as during air travel have been shown to predispose to DVT in adults,³ but never before in children.

We report the first instance of primary DVT in an otherwise healthy 12-year-old boy after prolonged immobility while using his video games console. He presented to the paediatric unit with unilateral swelling of the left calf, which was non-tender. The onset of his symptoms was preceded by prolonged immobilization while using his games console the day before. He had spent up to four consecutive hours that day playing on the console without an intermission. Furthermore, he had both legs flexed, with the calves beneath his buttocks, throughout this four-hour period. There was no family history of thrombophilia. When he was examined by the paediatric SHO and registrar, the diagnoses of DVT, fracture or infection were excluded clinically. A full blood count, C-reactive protein and coagulation screen were normal and he was sent home. Six days later, he returned with increase in left lower limb swelling and pain. On examination, there was venous congestion and severe swelling and tenderness of the left calf. Ultrasound scan showed thrombus in the left popliteal vein