

# 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](mailto:Clinicalmedicine@rcplondon.ac.uk).

### **A confidential study of deaths after emergency medical admission: issues relating to quality of care**

Editor – The pilot confidential study of deaths after emergency medical admission by Seward *et al* raises many important issues relating to acute medical care (*Clin Med* September/October 2003, pp 425–34). They highlight the negative impact of delay before assessment by a member of the medical team and the benefit of early senior review. Given that 70% of their study population are admitted through the accident and emergency department it would seem reasonable to assume that the seniority and timing of the patients' initial medical assessment by A&E staff might also have a significant influence on patient outcome. I wonder if they have any plans to incorporate such information in any developments of the pilot study? It is also slightly intriguing that their recording of whether patients were seen on a daily basis excludes weekends and bank holidays. Is it acceptable that acutely unwell patients are not seen for up to three (or in some hospitals four) days at a time?

JM JONES

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### **In response**

We thank Dr Jones for his interest in our pilot study. We did not investigate the role of accident and emergency staff specifically, but would agree that this would be a worthwhile addition for future studies. The organisation of care for acutely ill medical

patients varies hugely between trusts and there are few data from which to determine if care over the first 24 hours is best provided by the A&E team, by an acute admissions unit, or by traditional ward based systems, or combinations of all three. Such variable organisation is in itself justification for more detailed study.

His second point – the inherent conflict between a five-day basic working week and the seven-day continuous pattern of illness – remains one of the unsolved problems when running a hospital. The reduced hours of junior doctors, which become even more problematical as the European Working Time Directive comes into force, make the incongruence worse. We were impressed to find daily notes on a high proportion of patients on weekdays but did not ask questions about weekends – we agree this is a topic for a follow-on study.

Our study was a pilot and thus was not comprehensive, indeed once we had the data we could see that there are many more issues (including those raised by Dr Jones) that could be examined. A further study is needed. The National Confidential Enquiry into Peri-Operative Deaths (NCEPOD) has a long and successful track record in the analysis of surgically related deaths. This year while retaining the same acronym, its title has changed to the National Confidential Enquiry into Patient Outcomes and Deaths. The National Institute of Clinical Excellence (NICE) has commissioned NCEPOD to perform a study on medical deaths and we will pass on these and other comments to them. We have already shared our experience to date and are pleased that

one of our team (Dr Terry Wardle) has joined them as a clinical advisor. The Clinical Effectiveness and Evaluation Unit at the College will continue to be supportive of their project but will not be taking this further for the time being.

MG PEARSON

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### **General practitioners with a special interest in dermatology – the dermatologist's perspective**

Editor – I was interested to read Dr Lawrence's thoughtful article about general practitioners with a special interest (GPSIs) within the field of dermatology (*Clin Med* September/October 2003, pp 440–442). However, I think there was insufficient discussion on the impact of this initiative on the local hospital dermatology service. The article rightly states that most GPSIs will be recruited from the ranks of hospital clinical assistants, but in most district general hospital dermatology units these doctors, who are often very experienced, are an essential part of the hospital service. If they are not regularly in the hospital clinic the capacity will be significantly reduced and it will take some years for new clinical assistants to develop a similar experience. Some clinic space will also be needed to see the patients referred on from the GPSIs. Another consideration is that many of the present staff grades and associate specialists originally started as clinical assistants (although not all were GPs). Therefore it is likely that there will be problems with recruiting staff grades in the future, particularly as the pay is so much less attractive than that of a GPSI.

Another issue, which was not mentioned in this article but I think is extremely important, is education. At present the whole range of dermatology is seen in hospital clinics, and they are therefore suitable for the education of GP trainees and medical students, and provide excellent dermatology experience for the clinical assistants attached to the unit. If the case mix of the clinic is distorted by removing certain conditions, this will mean that the sort of patients being seen by the GPSIs are not in fact available in the clinics where the future

GPSIs are to be trained. This could make the whole system unsustainable. A clinic consisting only of obscure and complicated cases would also be unsuitable for undergraduate students, which would be a pity when it is so important that they do have a proper exposure to dermatology.

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## 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.

### Diarrhoea may be an important risk factor for deep venous thrombosis in the elderly

I read with interest Ng SM *et al*'s case report.<sup>1</sup> If the difficulty in recognising deep venous thrombosis (DVT) in children is understandable, failure to identify it in high-risk elderly patients is completely unjustified, as the incidence of DVT increases sharply with age, from one case per 100 000 people per year in childhood to nearly 1% per year in old age.<sup>2</sup> This high risk is at least partly due to the exposure of the elderly population to more or new risk factors, such as immobility and hospitalisation for either medical or surgical emergencies.<sup>3</sup>

We have audited the notes of 15 Elderly patients who developed either DVT or pulmonary embolism while in hospital after being admitted with either acute stroke (five patients) or Parkinson's disease. An interesting finding was that an acute diarrhoeal episode preceded the onset of DVT in five out of the 15 patients (33%). The diarrhoea started between two and eight days before the detection of DVT. Two of these five patients were admitted with a stroke and the three Parkinson's patients with sudden onset of immobility secondary to cancer colon, fractured hip and urinary tract infection, respectively four of the patients were men and one was a woman, and their age ranged between 75 and 86 with mean of 79.

Hyperviscosity secondary to dehydration is a well-recognised risk factor for DVT.<sup>4</sup> We feel that the elderly population is particularly vulnerable, especially if they have a neurological disorder such as stroke or Parkinson's disease, which might affect their swallowing, communication or cognition, thus increasing the risk of dehydration following a relatively mild attack of diarrhoea.<sup>5</sup>

Rosindaal<sup>2</sup> considered thrombosis as a multicausal disease. In order to develop

thrombosis, a patient must have several risk factors to exceed the 'thrombosis potential threshold'. If a patient is very close to the threshold, and one more risk factor is added, thrombosis will occur. It is important to consider this concept in the clinical setting to be able to stratify the patients at high risk of thrombosis, not just to implement adequate prophylactic measures such as elastic stockings and subcutaneous heparin, but also to aggressively try to reverse 'developing' risk factors such as diarrhoea by ensuring adequate hydration.

#### References

- 1 NG SM, Khurana RM, Yeang HW AW, Hughes UM, Manning DJ. Is prolonged use of computer games a risk factor for deep venous thrombosis in children? *Clin Med* 2003;3:593-4.
- 2 Rosindaal FR. Venous thrombosis: a multicausal disease. *Lancet* 1999;353:1167-73.
- 3 Heit JA, O'Fallon M, Petterson TM, Lohse CM *et al*. Relative impact of risk factors for deep vein thrombosis and pulmonary embolism. *Arch Intern Med* 2002;162:1245-8.
- 4 Mammen EF. Pathogenesis of venous thrombosis. *Chest* 1992;102(Suppl 6): 640S-644S.
- 5 Whelan K. Inadequate fluid intake in dysphagic acute stroke. *Clin Nutr* 2001;20:423-8.

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