great impact on health in hospital and the community. Much can be done in hospital to establish the much needed continuity of care between settings.

The RCP Nutrition Committee has focused the efforts of the College (itself a special interest group?) to improve standards of care and the training required to achieve this. The RCP publication *Nutrition and patients: a doctor's responsibility* encapsulates the ethos required of modern clinicians.[2] While it is true that much disease-related malnutrition can not be readily reversed, to suggest that only a minority of hospital patients need nutritional support is to fly in the face of the evidence. Encouragement of such negative attitudes leads to the classic 'we see no ships' response from clinicians who do not even regard weighing their patients as a useful activity. It is correct that we should be concerned about substandard hospital food, but many patients require artificial nutritional support to survive. In 2006, 36,500 adults and children received artificial nutritional in the UK community.[3] Most were introduced to these treatments as inpatients by clinicians working in multidisciplinary teams. In addition, as many as 15% of hospitalised patients receive oral nutritional supplements (supported by an evidence base), further emphasising that malnutrition is common in hospital.

The recent Nutrition Screening Week (supported by special interest groups such as the British Association for Parenteral and Enteral Nutrition, British Dietetic Association, Royal College of Nursing, National Patient Safety Agency, Department of Health, the governments in England and Scotland, the Welsh Assembly and Chief Nursing Officer in Northern Ireland) identified that 28% of 9,722 inpatients screened over three days in acute hospitals were at risk of malnutrition.[4] This figure rises to 38% in those aged over 60 – hardly an insignificant minority.

Nutrition is a basic human right. It is also the duty of all modern practising physicians to take a 'special interest' in the nutrition of their patients.

BARRY JONES
Chair, Nutrition Committee
Royal College of Physicians

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Editor's response to Elia and Jones

I apologise if my editorial gave the erroneous impression that I was 'dismissive of the importance of under nutrition in hospital, that little could be done about it and that it trivialised the problem'. The comment concerning special interest groups was directed not at societies like your own but, as suggested by the dramatic title 'Thousands starving in UK hospitals', to press reports and the tendency to trivialise the issue. This should have been made more explicit. The main purpose of the editorial, which has been obscured by this misunderstanding, was to promote improvement in hospital catering which has lagged well behind improvements in clinical care. This is an improvement that we would all support. To clarify the situation for our readers and redress the balance, we will invite the correspondents to contribute an editorial concerned with the analysis of the results from their recent important Nutrition Screening Week survey.

ROBERT ALLAN
Editor, Clinical Medicine

College comment on 'Thousands starving in UK hospitals'

I thought it might be helpful following the correspondence about the recent editorial about malnutrition in hospital if I stated the College's position. This is set out in detail in a College publication dated 2002 entitled *Nutrition and patients: a doctor's responsibility.* The College accepts that as many as 40% of patients are undernourished on admission to hospital and 2/3 of all hospital inpatients lose weight during their stay. Malnutrition impairs organ function and recovery from illness and nutritional support can improve nutritional state and reduce morbidity. However, as Professor Allan's editorial points out, nutritional support during a short hospital stay is usually not sufficient for patients who are undernourished and it is important that integrated nutritional care is continued into the community. Moreover, there are some patients for whom invasive procedures with risk to deliver artificial nutrition are inappropriate.

The College is committed to improving the nutritional care of patients in hospital and outside and encourages Fellows, Members and trainees to play a leading role in seeing that this is achieved. It believes that this is best achieved by a medically led multidisciplinary nutrition support team, both in hospital and outside. A nutrition advisory group should similarly exist in every hospital and the existence and activity of these should be part of the Healthcare Commission's Health Watch.

RODNEY BURNHAM
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Complexity of treatment decisions with older patients

Editor – The article by Martin and colleagues is most welcome, particularly in the light of the Mental Capacity Act 2007 (*Clin Med* October 2007 pp 505–8). As doctors receiving acutely ill, but obviously frail and elderly patients on a daily basis, my colleagues and I face a situation where there is a complete lack of any prior thought as to how the person should be managed in the event of them becoming ill. In Martin *et al*'s first case vignette, one has to ask why the patient's regular carers did not call her general practitioner (GP) rather than 'phoning for an ambulance'. If they had done this and if an appropriate conversation had taken place between the GP and the patient's family then the assault on the patient with intravenous (iv) drips and nasogastric tubes might have been avoided.

The situation is often even worse with people admitted from nursing homes: by definition such patients are dependent and somewhat frail, yet nursing homes do not seem to ask the question: 'if you/your mother/your husband becomes ill, how

should that illness be managed and what level of medical intervention would the person want?'. We frequently admit such patients without any information about their quality of life, prior wishes or capabilities, and it can take several days to get that information. In the meantime, we are faced with decisions about iv fluids, antibiotics, computed tomography scanning, resuscitation and a host of other potential interventions. Alternatively we are told that the person 'suffers from dementia' but we learn nothing about its severity, nor its impact is on the level of function. Martin *et al* are right to say that 'a value judgement on whether the . . . outcome [of treatment] is worthwhile' should be made by the patient and not by the doctor; the problem is that we almost never have the opportunity to discuss this decision in a timely manner and whether we like it or not some such decisions (for example, on 'do not attempt resuscitation' orders or intensive care admission) simply have to be made by doctors.

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Lesson of the month

Editor – I found Dr Mir *et al*'s lesson of the month interesting (*Clin Med* October 2007 pp 530–1). It is worth adding to their article by stating a few important points that are perhaps not appreciated by the wider medical community that come into contact with hypertensive patients.

Firstly, the vast majority of patients with primary aldosteronism are normokalaemic. Hypokalaemia is a late feature of Conn's syndrome or aldosterone-producing adenoma. In one series 67% of patients with aldosterone-producing adenomas were normokalaemic.[1] Thus the absence of hypokalaemia does not exclude primary aldosteronism. I would agree that hypokalaemia in a patient with hypertension who is taking thiazides could point towards a diagnosis of primary aldosteronism.

Secondly, the previously held notion that aldosterone-producing adenomas are uncommon has been challenged since the introduction of the aldosterone to plasma renin activity ratio as a screening tool. In one study there was a fourfold increased removal of aldosterone-producing adenomas resulting in the cure of hypertension in 60%.[2]

Thirdly, dihydropyridine calcium channel blockers, eg amlodipine and diuretics, can elevate renin levels resulting in a falsely normal aldosterone to renin ratio. Thus amlodipine and bendroflumethiazide could be withdrawn for a period no less than two and four weeks respectively with repeat renin/aldosterone studies. If blood pressure control is required in the interim then non-dihydropyridine calcium channel blocker such as dilitazem (safer than verapamil) or the alpha blocker doxazosin could be used instead.

Finally, it is very important that imaging is only carried out once biochemical confirmation of primary aldosteronism has been established. The incidence of non-functional adrenal adenomas increases over the age of 40 years. There are cases of primary aldosteronism arising from the contralateral adrenal gland in someone with an incidental adrenal adenoma in the opposite gland.[3]

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Lack of access to out-of-hours endoscopy: implications for trainees too

Editor – I wholeheartedly agree with the findings of Gyawali *et al*'s survey (*Clin Med* December 2007 pp 585–8) which concludes that there is significant underprovision of gastrointestinal (GI) emergency medical services in England. After initial resuscitation and physiological stabilisation of patients with GI emergencies, as a general medical (non-gastroenterology) trainee, I have repeatedly found myself (in centres with no established on-call rota) devoting significant time (with switchboard staff) trying to find an available endoscopist. I would rather spend such time re-evaluating and maintaining the stability of such patients who, as Gyawali *et al* state, are often extremely sick and complex to manage, requiring prolonged input. Therefore, the delay in accessing an on-call endoscopist (as well as their absence) is another factor which has the potential to impact on patient care in this setting.

Another important issue is that with the reduced number of GI emergencies admitted to some hospitals (for example because of redeployment of gastroenterologists to regional centres or neighbouring units) medical trainees may be underexposed or deskilled in the management of such emergencies in some centres. However, such emergencies can subsequently develop in hospital after admission because of critical illness. It is therefore essential that trainees have experience, confidence and expertise to mange these situations.

In conclusion, a robust and accessible system for on-call endoscopy is the goal but it is a challenging one because of resource and capacity issues. The suggested 'hub and spoke' model with regional centres may well be the solution but general medical trainees must rotate through them to attain sufficient experience and expertise to manage these emergencies whenever they arise.

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