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 sent by email to: Clinicalmedicine@rcplondon.ac.uk

Respiratory problems on the acute take: pleural disease and acute dyspnoea

Stevenson and Simpson provide an interesting insight on pleural disease (*Clin Med* June 2008 pp 288–91). However, I do not agree with some contents. Firstly, pneumonia, rather than malignancy, is the most common cause of exudates effusion.[1,2] Secondly, not all effusions require aspiration of pleural fluid, those having small bilateral effusions with clinical feature of congestive heart failure could be treated with diuresis and observation.[1] Thirdly, pleural infection is not synonymous with empyema.[2] Using empyema in the brackets next to pleural infection could mislead the audiences to believe that both words are identical.

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References

1   Light RW. Clinical practice. Pleural effusion. *N Engl J Med* 2002;346:1971–7.
2   Rahman NM, Chapman SJ, Davies RJ. Pleural effusion: a structured approach to care. *Br Med Bull* 2005;72:31–47.

In response

We thank the author for his comments. Parapneumonic effusions are the most common cause of an exudative pleural effusion in young patients. In patients over the age of 60 years, however, malignancy is the most common cause.[1]

The article particularly mentions that the treatment of a transudative pleural effusion should be aimed at the underlying cause. We agree with the comments regarding treatment of congestive heart failure where the diagnosis is often secure. However, in cases of uncertainty, it is necessary to perform diagnostic pleural aspiration.

Pleural infection is characterised by an effusion with a positive Gram stain/culture or frank pus.[2] The development of pleural infection is a continuum ranging from simple effusions to frank empyema. The use of the term empyema in parentheses was intended to clarify the subsequent epidemiological data.

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References

1   Chapman SJ, Davies RJO. Respiratory medicine. Pleural effusions. *Clin Med* 2004;4:207–10.
2   Davies CW, Gleeson FV, Davies RJ. BTS guidelines for the management of pleural infection. *Thorax* 2003;58(Suppl 2): ii18–28.

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.

Did not attends: Who, why, when?

Each year around 11.2% of outpatient appointments are missed. Each missed appointment costs the NHS about £100, equating to £134 million wasted each year in London alone.[1] Previous reviews have shown high variability in the 'did not attend' (DNA) rate (5–38% in the UK),[2] but they consistently show that the most common reasons were forgetting appointments or communication failures. Encouragingly telephone and written reminders have been shown to be effective in improving the DNA rate.[3] Rheumatology is a mainly outpatient service and so the DNA data from St Mary's Hospital, London, were studied in order to improve future efficiency.

Method

Over a four-week period details of all patients who missed their Rheumatology outpatient appointments were collected. Patient demographics and diagnosis, and details of appointment timing were all analysed. All patients who missed their appointment were called at home to establish reason for non-attendance.

Results

Data were collected from 63/80 (79%) rheumatology clinics, encapsulating 441 follow-up appointments and 96 new appointments. Overall, 83% of patients attended their appointments, with 69 DNAs and 21 late cancellations.

Who DNAs?

Most patients were female and aged between 45 and 59 years old but proportionally the