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.

WEEKITT KITTISUPAMONGKOL
Hua Chiew Hospital
Bangkok, Thailand

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.

NICOLA STEVENSON
Consultant in Respiratory Medicine
Wirral University Teaching Hospital

JON SIMPSON
Consultant in Respiratory Medicine
Manchester Royal Infirmary

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

worst attendees were 30–44-year-old men. There was also a core contingent of regular non-attendees, with 14/69 (20%) patients not attending ≥3 outpatient appointments in the last year. Patients with the whole spectrum of rheumatological disease missed appointments. As expected, most patient with musculoskeletal disorders (eg osteoarthritis) were discharged. While patients with rheumatoid arthritis, systemic lupus erythematosus and spondyloathropathies tended to be re-arranged appointments. Overall 46% patients had re-arranged appointments.

When do patients DNA?

Most appointments were missed on Monday (17.5%) and Friday (14%), compared to 4% on Wednesdays. Weather appeared to have very little effect on DNA rate, and was prospectively categorised as 'good' or 'bad' at 9 am or 2 pm. On 'good' days 12.4% of patients DNA, compared to 14.6% on 'bad' days.

Why do patients DNA?

Reasons for not attending appointments were divided into clerical errors, patient factors and unable to contact patient for variety of reasons. The most common reasons were in line with previous studies: 10/69 did not receive their appointment reminder and 9/69 forgot about it (Table 1).

Other notable findings included large numbers of clerical errors, including a patient registered as dead on the hospital computer still having several outstanding appointments, and frequency of incorrect contact details (13/69).

Conclusions

DNA rates at St Mary's rheumatology outpatient appointments are in line with national figures, but this still equates to about 20 hours of wasted clinic time over a four-week period leaving significant room for improvement. Suggested changes include:

- reminder texts/emails, targeting young patients who frequently miss appointments and have easy access to this form of communication
- targeted reminders for the 20% of patients who regularly DNA
- improve methods for cancelling appointment eg email
- careful review of DNA notes to prevent inappropriate rebooking
- reduce clerical errors by emphasising importance of booking correct type of appointment, and checking patient contact details at every opportunity.

GEORGINA MANSFIELD
Senior House Officer
St Mary's, Paddington, London

Table 1. Most common reasons for missed appointments.

Category	Reason	n
Unable to contact patient	Patient could not speak English	2
	No reply × 3	19
	Wrong number	7
	No phone number	6
Clerical errors	Appointment not cancelled	1
	Patient attended	1
	Appointment card did not correspond to appointment time	1
	Wrong hospital booked	1
	Wrong appointment booked	3
	Inconvenient time	4
	Did not receive appointment	10
Patient factors	Other	5
	Arrived late for appointment	2
	Resolved	3
	Ill on day of appointment	5
	Forgot appointment	9

References

1 Information Centre for Health and Social Care. www.ic.nhs.uk
2 Did not attend. *Bandolier* 1999;69–4. www.jr2.ox.ac.uk/bandolier/band69/b69-4.html
3 WM Macharia et al . An overview of interventions to improve compliance with appointment keeping for medical services. *JAMA* 1992;267:1813–17.

A system for prescribing oral potassium supplements

Introduction

Hospital inpatients often need oral potassium supplementation. Ensuring safe administration requires regular checking of serum potassium. Clear instructions are needed about the dose, target potassium level, frequency of blood testing and the results. We have developed guidelines to support safer administration.

Guidelines on oral potassium supplementation

When prescribing oral potassium (Fig 1), the prescriber should:

- write K^+ and the initial value of serum potassium on the first line of the administration record in red
- choose a suitable preparation of potassium and dose regime
- prescribe the potassium at 12.00 and 18.00 for a twice daily regime (and also at 22.00 for a thrice daily); this allows that day's blood test to be available before the first administration times. NB. If a slow release preparation of potassium (eg Slow K®) is chosen, it should not be prescribed at 22.00, to avoid the risk of oesophageal ulceration
- specify the target serum potassium level that is required in the box for special instructions
- specify the date when the serum potassium level is to be checked by drawing a box on the administration record (this should usually be daily)
- complete the necessary pathology request forms for the potassium levels to be checked.