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: Bettina.Klar@rcplondon.ac.uk.

Giving or withholding fluid and nutrients

Editor – In his article concerning artificial nutrition, Lennard-Jones presents a well reasoned and thought out discussion (January/February 1999, pp39–45). It is suggested that enteral feeding can be considered a medical treatment and could be used as a trial of nutrition, akin to a trial of antibiotics for an infection, or dopamine in the diagnostic quandary of Parkinsonism.

In the case of stroke patients, the situation is more complex than that of patients in a persistent vegetative state. In the latter the extent of brain injury is fixed, but in the former – especially in the early stages – brain function can improve. Many people presenting acutely with stroke will have swallowing problems and a proportion are also very drowsy. Fortunately, in many the swallow improves quickly, and often enteral feeding does not occur or is not considered desirable. There are others who improve physically, but their swallow does not. These people should be provided with nutrition and I doubt that there would be much argument. Others, following stroke, are dying and palliative care should be offered. But what about a middle group of patients: those that begin to improve but then plateau? What are we to do? Should enteral nutrition be offered or not and when should it be offered?

Lennard-Jones would suggest that a trial of nutrition should occur, but how soon after admission, and once commenced, for how long? A trial of nutrition may cause more problems than it solves. How is success to be measured; what constitutes an improvement? What the medical and nursing staff may consider to be a lack of improvement, the family may not.

The issue of futility remains: when is it futile to commence nutrition in these patients, especially as our management must be to do good and not harm? The major issue is not whether a trial of nutrition should commence which then raises moral difficulties about stopping. It must be targeted more at determining who should receive nutritional support in the first place.

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Maintenance of clinical guidelines

Editor – It was encouraging to read of the remodelling of the College’s Research Unit, which has now become the Clinical Effectiveness and Evaluation Unit (May/June 1999, pp241–5) and of the Unit’s continuing role in the development of clinical guidelines. What was not made clear was the strategy to be adopted to ensure the maintenance of these guidelines. A problem commonly encountered in practice is that of the clinical guideline created in good faith, but which has become faulty with the passage of time.

Clinical guidelines are intended to improve provision of medical care by describing readily accessible and accepted standards of care. What is not discussed are the implications of potential medical malpractice due to either non-adherence to, or inaccuracy of, clinical guidelines. There are understandable concerns that failure to adhere to clinical guidelines will result in liability. We can be relatively reassured when we read that ‘guidelines should not be used as the sole determinant of the standard of care’ but should be treated as ‘one piece of evidence to be weighed by the jury’1. In addition, those who are involved in the formulation of clinical guidelines should be aware that US courts have ruled that they can be held liable for their faulty guidelines2.

As the authors of clinical guidelines we have a responsibility to review them on a regular basis and to update them in the light of the latest evidence-based practice, advances in medical technology, and current research3. Any medical body dedicated to the formulation of clinical guidelines must have a clearly defined strategy to ensure this is carried out.

References
1. Jacobson PD. Legal and policy considerations in using clinical practice guidelines. Am J Cardiol 1997;80(8B):74–91.
2. Hurwitz B. Clinical guidelines and the law. J Evaluation in clinical practice 1995;1:49–60.
3. Brennan TA. Practice guidelines and malpractice litigation. J Health Polit Policy Law 1991;16:67–85.

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In response

Editor – I entirely agree with Dr Playfor that clinical guidelines should be reviewed regularly. However, the reality is that selecting and reviewing evidence, assembling a group of experts together, and the actual production inevitably costs money, and there is no funding mechanism in place. Many guidelines have been supported by grants from the pharmaceutical companies and others. This is far from ideal and is a matter for continued discussion, both with the specialist societies who often do much of the hard work in producing guidelines, and of course with NICE who are likely to have the administrative responsibility for funding such activity.

As medicine is rapidly changing, it is inevitable that some of the details in a guideline document become out of date. However, as long as the major planks of the guideline remain valid it is probably not necessary to consider a formal revision more often than every three to four years. Most physicians are sensible enough to be able to interpret the guideline in the light of more recent papers supporting newer procedures or treatments.

The litigation worry has so far been more theoretical than real. It is well established that guidelines are not protocols and that there will always be
some patients who require treatment other than that recommended as mainstream by the guideline. Few of us would have a problem supporting a colleague who has treated a patient without the guideline recommendation but for clearly stated and logical reasons. It is the doctor who deviates without thought and with no stated reasons who will have few friends.

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Lowering cholesterol

Editor – It was good to see that over the past two years1 Professor Oliver has raised his upper limit for treating hypercholesterolaemia by 10 years from 65 to 75 (May/June 1999, pp252-3). His opinion that ‘hypercholesterolaemia is not a risk factor for chronic heart disease (CHD) in the elderly’ is not supported by his quoted references. The first line of the discussion of the Zutphen Elderly Study involving men aged 64–84 states that ‘The main results of this study show that in elderly men, followed for 5 years, total cholesterol is an independent risk factor for mortality from CHD’.2 Similarly, the claim of the correlation between CHD and raised cholesterol disappearing in those aged 80 and over is a misrepresentation of data from a study containing patients aged 85 years and older.3 I find it contradictory that Professor Oliver argues that it is ‘unethical (in view of the successful outcome of primary and secondary prevention trials in middle-age) and uneconomic to mount a controlled clinical trial to test the efficacy of statins against placebo in the elderly’ and then states that as there are no valid data for patients over 75 that ‘it is unsound to extrapolate the positive trial results from middle-aged patients or otherwise healthy people and use these as an argument for treating raised cholesterol levels in the elderly’. It could only be unethical to mount such a trial if he believed that statins did have beneficial effects in the elderly, in which case he himself has extrapolated trial data from middle-aged to elderly people. His argument for not treating raised cholesterol in the over 75s is reduced to an economic one. Discrimination by age for rationing purposes is as illogical as discrimination by gender, race or religion. The LIPID trial data suggest that elderly patients do benefit from pravastatin.4 The decision to treat should be based on life expectancy and not an arbitrary age and it should be remembered that even at 80, life expectancy of men is around 6.5 years and for women around 8.5 years.

References
1 Oliver MF. Should we treat hypercholesterolaemia in patients over 65? Heart 1997; 77:491-2
2 Weijenberg MP, Feskens EJM, Kromhout K. Total and high density lipoprotein cholesterol as risk factors for coronary heart disease in elderly men during 5 years of follow-up. Am J Epidemiol 1996; 143: 151-8
3 Weaverling-Rijsburger AWE, Blauw GI, Lagaay AM, Knoek DL, Meinders AE, Westendorp RGJ. Total cholesterol and risk of mortality in the oldest old. Lancet 1997; 350: 1119-23
4 The Long-term Intervention with Pravastatin in Ischaemic Disease (LIPID) Study Group. Prevention of cardiovascular events and death with pravastatin in patients with coronary heart disease and a broad range of initial cholesterol levels. N Engl J Med 1998; 339: 1349-57

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Sleep apnoea

Editor – Professor Oliver’s timely article on lowering cholesterol in those aged 80 years and over (May/June 1999, pp252-3) is entirely in accord with my own long-established practice for many of the same reasons. However, of late, I have become increasingly troubled over this practice in the case of patients of this age with diabetes, especially those who have had a myocardial infarction. About 20% of the elderly will have type II diabetes, commonly in association with lipid abnormalities. Although the CARE study5 did not include patients of this age, it did show that those with diabetes had a greater reduction in coronary events following treatment with pravastatin than those without diabetes. While not all older people are considered suitable for aggressive management of their diabetes (owing to the presence of co-morbid factors), a significant minority are, however, considered suitable. Despite the absence of proven benefit, I am no longer certain that in these patients, for whom we advocate major lifestyle modifications and vigorous management of hypertension and microalbuninuria, it is reasonable to withhold pharmacological interventions for their lipid disorders. I would very much welcome some guidance.

Reference
1 The CARE study. N Engl J Med 1996; 335: 1001-9.

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