Letters to the editor

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Austrian syndrome
DOI: 10.7861/clinmed.Lett.20.2.1

Editor – thank you for publishing the article about Austrian syndrome.1

There is just one thing I would like to mention; the article ends with “We also propose that this syndrome should be renamed as Osler’s syndrome with Osler’s tetr”, in acknowledgement that Sir William Osler was the first to describe the triad of pneumonia, meningitis and endocarditis with presence of ‘micrococi’ in affected tissues and blood.

I am aware that there is a language barrier as some really old articles are in German, but it is not the full truth that Osler was the first; Mandal et al’s article does not mention Richard Heschl at all. Heschl described a case series of patients with endocarditis, pneumonia and meningitis in 1862.2 If we take the historical background into account, and the fact that there was no ‘bacteriology’ in the 1860s (eg Ferdinand Julius Cohn published ‘Untersuchungen über Bakterien’ in 1872, Robert Koch was the first to describe the triad of pneumonia, meningitis and endocarditis with presence of ‘micrococi’ in affected tissues and blood), then to name the pathophysiology something like ‘Pneumococcal or do as with all the other syndromes and get rid of the eponymous name and call the pathophysiology something like ‘Heschl syndrome’, I would like to propose another approach, if we have to rename the syndrome (do we have to?), then to name it Heschl syndrome, or do as with all the other syndromes and get rid of the eponymous names and call the pathophysiology something like ‘Pneumococcal multiorgan infestation syndrome affecting heart, lung and central nervous system’ as a (very long – apologies) description for the multiorgan infestation syndrome affecting heart, lung and central nervous system as a (very long – apologies) description for the syndrome.

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References
1 Mandal AKJ, Mohamad B, Missouris CG. Lessons of the month 3: Gone but not forgotten – Osler – a reminder of the syndrome not bearing his name. Clin Med 2019;19:523–5.
2 Heschl R. Pathologisch-anatomische Mittheilungen aus dem Grazer allgemeinen Krankenhaus: 4. Zur Casusistik und Aetiology der Endocarditis (Fortsetzung). Wien: Oesten Ztschr prakt Heilk; 1862;8:238.

Perioperative diabetes management in patients with kidney disease
DOI: 10.7861/clinmed.Lett.20.2.2

Editor – We read with interest the article ‘Perioperative diabetes care’ by Ketan Dhatariya and Nicholas Levy.3

We wanted to highlight the challenges involved in management of diabetic patients with chronic kidney disease (CKD), acute kidney injury (AKI) and AKI on CKD. We believe that it is important to note the role CKD and AKI play in the management of patients with diabetes. There is a well-known association between diabetes and development of CKD. Mathew et al found that CKD was an independent risk factor for postoperative morbidity and mortality, with a strength of association similar to that of diabetes, stroke or coronary disease.2

The risk of side effects of some antidiabetic medications, such as metformin and thiazolidinediones, increases in patients with CKD. Zanchi et al have concluded that only sitagliptin, saxagliptin and linagliptin may be used in advanced kidney disease, while GLP-1 agonists are contraindicated.3

Furthermore, there are multiple mechanisms by which surgery can lead to the development of AKI, especially in patients with a known history of CKD. The use of non-steroidal anti-inflammatory drugs for pain management, contrast-media for imaging studies and volume depletion during surgery are all contributing factors. Hobson et al recommend using different predictive strategies, including scoring systems and clinical judgement to determine the risk of AKI in patients undergoing surgery.4

Some hospitalised patients are on anticoagulants for various reasons. Anticoagulation-related nephropathy is a significant but underdiagnosed complication of anticoagulant treatment. It is mostly commonly associated with warfarin but some studies suggest its association with novel anticoagulants as well.5

There is a known strong association between type 2 diabetes and atrial fibrillation, increasing the likelihood that the patients have been prescribed anticoagulants. We therefore believe that more detailed guidelines are needed to determine the best approach to perioperative management of patients with diabetes and comorbid kidney disease, including finding the best AKI prevention strategies, reducing the risk of medication side effects, finding the optimal anticoagulation regimen and ensuring long-term renal protection.

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References

1. Dhatisa K, Levy N. Perioperative diabetes care. Clin Med 2019;19:437–40.
2. Mathew A, Devereaux PJ, O’Hare A, et al. Chronic kidney disease and postoperative mortality: a systematic review and meta-analysis. Kidney Int 2008;73:1069–81.
3. Zanchi A, Lehmann R, Philippe J. Antidiabetic drugs and kidney disease—recommendations of the Swiss Society for Endocrinology and Diabetology. Swiss Med Wkly 2012;142:w13629.
4. Hobson C, Ruchi R, Bihorac A. Perioperative acute kidney injury: risk factors and predictive strategies. Crit Care Clin 2017;33:379–96.
5. Wheeler DS, Giugliano RP, Rangaswami J. Anticoagulation-related nephropathy. J Thromb Haemost 2016;14:461–7.

Making every contact count: the role of the clinician in smoking cessation during the perioperative period

DOI: 10.7861/clinmed.Let.20.2.3

Editor – We read the paper by Durrand et al about setting up prehabilitation services with interest and would like to highlight our learning and insight from a local smoking cessation service for perioperative patients. Smoking is an independent predictor of postoperative complications, and modifications have shown to improve outcomes after surgery. The perioperative period can be an auspicious time to address risk-taking behaviours, like smoking, as patients may be more receptive to making positive changes that can impact their health. Clinicians can play an important role in patient behavioural change by using strategies like Making Every Contact Count (MECC). Smoking has been recognised as the main cause of preventable illness and premature mortality in England and is associated with increased perioperative risk and delayed postoperative recovery.

Trends in recruitment into core medical training in the UK – could doing quality improvement projects help?

DOI: 10.7861/clinmed.Let.20.2.4

Editor – Butterworth and colleagues highlight the problems of recruiting and retaining enough medical trainees. They also mention there is a similar crisis in general practice. As medical students who were recently encouraged to become general practitioners (GPs) by conducting quality improvement projects in primary care, we would like to share what we learned. We hope it might be of interest to medical specialties.

References

1. Durrand J, Singh SJ, Danjoux G. Prehabilitation. Clin Med 2019;19:458–64.
2. Leeds IL, Efron DT, Lehmann LS. Surgical gatekeeping-modifiable risk factors and ethical decision making. NEJM 2018;379:389–94.
3. Public Health England. Making Every Contact Count (MECC): Consensus statement. PHE Publications, 2016. www.england.nhs.uk/wp-content/uploads/2016/04/making-every-contact-count.pdf [Accessed 10 December 2019].
4. National Statistics. Statistics on smoking. NHS, 2019. https://files.digital.nhs.uk/D9/5AACD3/smok-eng-2019-rep.pdf [Accessed 10 December 2019].
5. Turan A, Mascha EJ, Roberman D et al. Smoking and perioperative outcomes. Anaesthesiology 2011;114:837–46.
6. National Institute for Health and Care Excellence. Stop smoking interventions and services. NICE guideline [NG92]. NICE, 2018. www.nice.org.uk/guidance/ng92/resources/stop-smoking-interventions-and-services-pdf-1837751801029 [Accessed 10 December 2019].

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Trends in recruitment into core medical training in the UK – could doing quality improvement projects help?

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Editor – Butterworth and colleagues highlight the problems of recruiting and retaining enough medical trainees. They also mention there is a similar crisis in general practice. As medical students who were recently encouraged to become general practitioners (GPs) by conducting quality improvement projects in primary care, we would like to share what we learned. We hope it might be of interest to medical specialties.

To start with, we looked at a range of audits that might be useful to the practice and chose topics based on personal interest. We found it exciting for us as students to have the possibility of influencing clinical practice and improving patient care. This made our projects more enjoyable in terms of academic learning.

We found general practice was a friendly and supportive environment for carrying out an audit. Learning how to create our own databases and doing simple statistical analysis made us feel more confident about carrying out future audits exploring the gaps between guidelines and practice.

We discovered a common theme in our audits – the tension between adhering to national guidelines and feasibility in busy, everyday practice. An example of this was one of our audits looking at whether GPs comply with National Institute for Health and Care Excellence guidelines to screen patients with...