LETTERS TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters can be submitted on disk or sent by e-mail to: Bettina.Klar@rcplondon.ac.uk

Fast-tracking of MI

Editor – Fast-tracking of patients with myocardial infarction (MI) to CCU by paramedics (January/February 1998, pp 36–8) may be the best that can be done in a hospital whose A&E department does not have the facilities for coronary thrombolysis, but in many countries it is now well recognised that the A&E department is the best site for initiating intravenous thrombolysis in MI1. Any facility that aims to provide a 24-hour emergency service with the support of a dedicated coronary care unit, can reasonably be expected to provide an emergency department protocol for dealing with acute MI that results in a targeted clinical examination and a 12-lead ECG within 10 minutes and a door-to-needle time ideally within 30 minutes, and certainly within 60 minutes. The responsibility for the clinical assessment, ECG interpretation and decision to lyse rests firmly with the staff of the A&E department. The authors give us no real information on the status of the department which they serve.

Current recommendations emphasise the value of having medical controllers available on-line in emergency medical services systems where pre-hospital 12-lead electrocardiography is performed1. ECGs are transmitted electronically and their interpretation confirmed by the controllers who invariably are emergency physicians. This has reduced the time to thrombolysis following the patient’s arrival in the A&E department.

Banerjee and Roden state that the mean time to thrombolysis following a call for help was significantly greater in those patients admitted through the A&E department. Since most patients do not seek medical care for two hours or more after onset of symptoms, it would have been interesting to know the time between symptom onset and call for help, EMS response times, time spent at the scene, transport times and the ‘door-to-needle’ time in the A&E department. This knowledge might have identified areas where delays could be reduced.

Following MI, it should not be necessary to transfer patients from the A&E department to CCU before they receive intravenous thrombolysis1; this principle is agreed by A&E physicians and most cardiologists. Emergency physicians should co-operate closely with their medical colleagues to ensure prompt reception and appropriate triage, assessment, selection and therapy of patients with chest pain and at risk of myocardial infarction. Guidelines for the management of such patients are widely available and should be applied appropriately in individual institutions. At present, A&E departments and physicians are in the best position to take responsibility for the initial care of such patients. There is no evidence at this time to support the conclusion that this responsibility should be delegated elsewhere1.

Reference

1 Ryan TJ, Anderson JL, Antman EM, et al. Guidelines for the management of patients with acute myocardial infarction. Report of the American College of Cardiology and the American Heart Association Task Force on Practice Guidelines (Committee on Management of Acute Myocardial Infarction). J Am Coll Cardiol 1996;28:1328–42.

Thyroid nodules

Editor – the review of management of thyroid nodules (January/February 1998, pp 6–10), would be incomplete without allusion to metastasis to the thyroid gland1. Therapeutic implications of recognition of metastasis include the possibility of complete cure, following thyroidectomy, in isolated thyroid metastases originating from primary renal carcinoma2, and regression of thyroid metastases originating from breast carcinoma, following the use of tamoxifen1.

References

1 Nakhjavani MK, Gharib H, Goellner JR, van Heerden JA. Metastasis to the thyroid gland: a report of 43 cases. Cancer 1997; 79:574–8.
2 Kiemey PC, van Heerden JA, Segura JW, Weaver AL. Surgeon’s role in the management of solitary renal cell carcinoma metastasis occurring subsequent to initial curative nephrectomy. institutional review. Ann Surg Onc 1994;1:345–52.
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The future of general medicine

Editor – JR Hampton and A Gray (January/February 1998, pp 39–43) show that most emergency medical admissions are elderly patients, many of whom have multiple problems or need access to therapists or community facilities. Thus special expertise in care of the elderly is an essential skill in emergency medicine1. As emergency units increase in size, there are likely to be more patients over a 24-hour period than can be managed by one emergency team. The solution, extremely successful in our hospital, of having two emergency teams, one for patients over and one for those under 75 years with good liaison and support between teams, may be an important part of the future of general medicine.

Reference

1 Kafetz K, O’Farrell J, Parry J, Wijesuriya V, et al. Age related geriatric medicine: relevance of special skills of geriatric medicine to elderly people admitted to hospital as medical emergencies. J R Soc Med 1995;88:629–33.
whether it is the most appropriate pattern of care for the future.
In surgery the pressures for specialisation come from the recognition that surgeons who see only a few patients with a particular disease do not provide the best care. Against this background we are asking the physician to be pluripotential. How many of our colleagues would wish their nearest and dearest to have their gastrointestinal haemorrhage managed by their colleague in diabetes or respiratory medicine rather than in a gastroenterology unit with staff skilled in the management of this problem? In Nottingham some acute admissions do go to appropriate specialist units, eg CCU, and we feel that this principle should be applied across all specialties.

The weakest part of Hamptom and Gray's scheme is the designation of patients for whom specialty care was deemed essential, those for whom it was deemed desirable and those for whom it was deemed less important (the vast majority). The choices are bound to be strongly influenced by the custom and practice in the hospital and the organisation of beds and staff. Resources often dictate the pattern of care, particularly in relation to medicine for the elderly.

Much of the debate about general medicine hinges on who cares for older people. Age should be no barrier to specialty care and we do not advocate age-related admissions policies. We suggest that specialists working with generalists skilled in the management of older people, would provide the best care.

The strength of specialisation lies not only in the management of the rare but also in the good management of the common conditions. We accept that protocol driven care in the first 24 hours in an intensively staffed admissions area may be necessary for practical reasons of medical and nursing staffing, but we do not agree that this should dictate a generalist pattern of care for all other admissions. We have avoided this in our own hospital by establishing a new post of acute physician consultant at the interface between A&E, the acute assessment area and specialty wards. We have previously shown, in contrast to the Nottingham experience, the value of having a senior doctor in reducing the rate of acute admissions.5

All small district general hospitals are under pressure for a number of reasons such as junior doctors' hours, implementation of Calman and availability of specialists. We are already seeing the amalgamation of hospitals to form larger units and we suspect that in a few years time most hospitals will have the required range of specialty care to cover the range of acute admissions. It is important that this debate continues and we believe that the College has a pivotal role in clarifying the role of the generalist and specialist in both acute and ongoing care.

References
1 Masson J, Bramley P N, Herd K, McKnight G M, et al. Upper gastrointestinal bleeding in an open-access dedicated unit. J R Coll Physicians Lond 1996;31:436–42.
2 Wanklyn P, Hosker H, Pearson S, Belfield P. Slowing the rate of acute medical admissions. J R Coll Physicians Lond 1977;31:173–7.

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Symptoms and their management in hospital inpatients

Editor – High rates of unpleasant symptoms have been demonstrated in dying patients. The importance of controlling distressing symptoms in this group of patients undisputed, and experience in palliative medicine suggests that it can be achieved in the majority of instances. As members of a hospital palliative care team we became concerned about the low priority given to symptom control in other hospital inpatients. We therefore performed a simple questionnaire study to look at the prevalence of five common symptoms in a random sample of 148 adult inpatients. If the symptom had been present in the 24 hours prior to questioning, the patient was asked to rate it on a verbal scale (mild–moderate–severe). Of the 148 patients, 34 had cancer (at various stages), and 114 had non-cancer diagnoses.

Table 1 shows the prevalence of the five symptoms. For all patients (pain, breathlessness, nausea/vomiting, constipation) there was no significant difference in the prevalence of each symptom between cancer and non-cancer patients (analysis by chi-squared test, with significance if p<0.05). There was a significant difference in the prevalence of sore mouth (p<0.01) which may be explained by mucosal damage by anti-cancer treatments, immunocompromise and increased susceptibility to candidal infection in the cancer patients.

The same 148 patients’ prescription charts were also analysed and the prescription and administration of symptomatic therapies (eg analgesics, aperients, antiemetics) was evaluated, in particular in those patients complaining of moderate or severe symptoms. Often, patients were not receiving appropriate symptomatic therapies for a variety of reasons: no prescription had been written; an ‘as required’ prescription had been written, but not given; or ‘as

Table 1. Prevalence of common symptoms in adult inpatients.

| Symptom          | All patients n=148 (%) | Patients with cancer diagnosis n=34 (%) | Patients with non-cancer diagnosis n=114 (%) |
|------------------|------------------------|----------------------------------------|---------------------------------------------|
| Pain             | 87 (59)                | 16 (47)                                | 71 (62)                                     |
| Breathlessness   | 35 (24)                | 7 (21)                                 | 28 (25)                                     |
| Nausea/vomiting  | 26 (18)                | 5 (15)                                 | 21 (18)                                     |
| Constipation*    | 42 (28)                | 13 (38)                                | 29/102* (28)                               |
| Sore mouth       | 20 (14)                | 9 (26)                                 | 11 (10)                                     |

* Patients with intestinal obstruction or recent pelvic or abdominal surgery (12 in the non-cancer group) were excluded from the data on constipation.