Letters to the Editor

Ion-selective electrodes

Sir,

In their review of hyponatraemia, Gill and Leese1 identify hyponatraemia as a methodological problem which can lead to a spuriously low sodium. However, their assertion that this is not a problem when an ion-selective electrode (ISE) is used for sodium analysis needs clarification.

Two types of methods using ISEs are currently in use within clinical laboratories. In direct ISE methods the specimen is brought to the electrode surface without dilution and in indirect ISE methods the specimen is diluted with buffer prior to electrode contact. As the problem of hyponatraemia is related to the dilution of specimen, the more commonly encountered indirect ISE methods will suffer the same error as the older flame photometer technique.

This problem is explained by the solvent exclusion effect. Sodium is only distributed in the aqueous phase of a plasma specimen and if the non-aqueous fraction increases, for whatever reason, then a dilutional effect will result. The degree of error will be proportional to the volume occupied by the non-aqueous portion of the specimen, and both liquids and protein will contribute.

A question we quite often encounter in the laboratory relates to the magnitude of likely error. When we had access to a direct reading ISE which produced comparable results to our routine indirect reading ISE (mean difference 0.5 mmol/l, range 0 to +5 mmol/l, n=19, p=0.11) we briefly investigated the problem. Four specimens with visible lipaemia gave a mean difference of −4.8 mmol/l, range 4 to −5 mmol/l. Five specimens with raised total protein (greater than 80 g/l) gave a mean difference of −6.8 mmol/l, range 3 to −15 mmol/l. The degree of error observed is in broad agreement with a correction table which has been published.1

In summary, indirect reading ISE devices are in common usage and are subject to hyponatraemia. When hyponatraemia is suspected, discussion with the local laboratory and access to a direct reading ISE (sodium in an integral part of blood gas instrumentation) will be of value.

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A young man with repeated thromboses

Sir,

We read with great interest the case report by Kakar et al2 describing a young man with repeated thromboses. We would, however, like to draw to your attention a serious omission in this article. The clinical description of the young man included erythema nodosum and thrombotic episodes (in particular superior sagittal sinus thrombosis) is highly suggestive of Behcet’s disease. This diagnosis is frequently missed in cases of recurrent thrombosis and should be highlighted here, as therapeutic intervention by, for example, cyclosporin A or cyclophosphamide, may have prevented further thromboses and potential mortality.

In Behcet’s disease thrombosis, usually venous and, occasionally arterial, occurs in 10–25% of patients, usually presenting as thrombophlebitis in thighs or calves. In a minority of cases, large veins are involved, including superior and inferior vena cava, superior sagittal sinus and hepatic veins. Amongst those with significant vascular disease, 25% are venous and 7% arterial and 68% combined venous and arterial disease.1 Venous thrombosis in Behcet’s disease is associated with a non-specific vasculitis of large veins which on histopathological examination reveals perivascular lymphocytic infiltration. Finally, Kakar et al2 mention an association between Behcet’s disease with Factor 5 Leiden accounting for 20% of cases. However, they fail to mention that up to 37.5% of patients with Behcet’s disease are positive for Factor 5 Leiden, compared with 5% of control patients with rheumatoid arthritis.3 However, we believe that Behcet’s disease remains a strong possibility for the underlying diagnosis in this patient and should be actively considered in similar clinical scenarios with the institution of immunosuppressive therapy in parallel with anticoagulants.

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This letter was shown to the authors who responded as follows:

Sir,

We appreciate the thought-provoking diagnosis of Hutchison et al for our case. Behcet’s disease was considered in the differential diagnosis in our patient but was ruled out as the patient did not fulfil all the required criteria for the same. The diagnosis of Behcet’s disease should be based on the International Study Group (ISG) diagnostic criteria,1 and not clinical judgement alone. ISG criteria include recurrent oral ulcers and two of the following: recurrent genital ulcers, eye involvement, skin lesions and positive pathergy test. The sensitivity of this set of criteria for the diagnosis of Behcet’s disease is 95% and the specificity is 98%. Eye involvement in the form of uveitis (anterior or posterior) or cells in vitreous fluid on slit lamp examination or retinal vasculitis was not present in our patient. Our patient also did not have genital ulcers or positive pathergy test. Thrombosis, although an important manifestation of this condition, is not a diagnostic criteria.

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Communication skills

Sir,

In his recent editorial Dr Abdallat touches on some important points about communication skills and the professionalism of doctors.1 Though his assertions might be true as generalisations it would be misleading to appeal to one of them in National Health Service (NHS) practice. (My comments are confined to the NHS.) For example, it would be wrong to say that “the term consultant . . . means a person who is consulted”. The problem lies in the fact that language has evolved beyond this original literal usage. Today Consultants (capital ‘C’) are not Consultants because they are consulted, rather they are consulted because they are Consultants. Such status is conferred by appointment only on specific individuals who assume ongoing ultimate clinical responsibility for particular patients within a certain area of medicine or surgery. Though only those who have completed approved specialist training may be appointed Consultants, not all those who are suitably qualified are appointed. It would be misleading to say that a Staff Grade doctor who seeks a patient referral to Consultant may be called a consultant (small or large ‘c’ — they sound the same), even solely for the purposes of that referral. Likewise if a General Practitioner refers to, or consults with, a General Practitioner colleague. It is wrong to say that onwards referral should not proceed “without the knowledge and consent of the primary physician…”. In making the referral, the primary physician passes on clinical responsibility for a particular problem to a Consultant. When the Consultant sees the patient their interests come first, and if onwards referral is indicated then it should occur. In practice, one of two paths is taken, depending on the degree of clinical need. If onwards referral is unequivocally in the best interests of the patient the Consultant should do this without delay, and at the same time inform the primary physician. When the need is less clear, the Consultant should air the arguments for and against onward referral in the report to the referring physician, and state clearly that the responsibility for the decision about onwards referral has been passed back to the referrer.

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The question of ‘writing orders’, or not, which occurs in the context of in-patient referrals, when one team consults another, is a difficult one. Should the consulted team write a list of things to do, or should they go ahead and organise the investigations and treatment if they feel they are necessary? Which is the more courteous? The terms of the referral might suggest the more appropriate response, but the final arbiter should be the patient’s best interests.

Some points in the editorial which clearly do apply within the NHS are worth emphasising. The suggestions that the referrer should prepare the patient’s expectations; should clearly indicate the scope of the referral to the Consultant; and that the Consultant should present a timely report to the referring physician, are all very apt and we would do well to heed them. The final assertion that “open communication is the cornerstone of a successful consultation” is worth serious contemplation.

**Book reviews**

**ABC of mental health, T Davies, T Craig, eds, 80 pp, illus. BMJ Publishing Group, London, 1998. £16.95, paperback**

This book first appeared as a weekly series in the BMJ and has been re-published as a short book of 20 chapters, covering topics related to mental health. The style of the book is one of brief notes with boxes and bullet points outlining those facts which are most important.

The book is designed to be read not only by doctors but also by other professionals involved in mental health, such as nursing, social work, the legal profession and the police. The style is non-specialist and, although the chapters are brief, they contain the key facts about each area.

The book covers many areas of importance to doctors practising in the general hospital. The initial chapters concentrate on mental health assessment and on mental health emergencies as well as particular mental health problems presenting in general hospitals. There then follow a number of chapters reviewing the range of mental illness and presenting the essentials of aetiology, diagnosis and management. The final chapters relate to particular groups of patients, such as children, ethnic minorities and the homeless. There are also chapters on the law and drug and psychological treatments.

This book is clearly aimed at the non-psychiatrist. It would be a particularly useful book to be available in casualty departments, and many general practitioners and surgeons would find it helpful in refreshing their knowledge about particular conditions or management option. It provides an introduction to physicians on the management of common conditions they may encounter, such as depression and alcoholism. It also helps explain the principles of techniques such as cognitive behavioural therapy. It is clearly written and attempts to provide practical advice and current mainstream opinion on topics covered. It uses non-technical language wherever possible and hopefully will lead to greater recognition and dialogue between physicians and psychiatrists. The management of difficult somatising patients or the intricacies of the mental health act are difficult to deal with in brief note form but there is in this book a framework that helps to clarify these difficult areas. I would recommend it as a useful addition to most departments and would strongly advise casualty departments to have a copy available.

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**Postgraduate surgery: the candidate’s guide, 2nd edn, Mar Al-Fallouji, pp 665, illus. Butterworth Heinemann, 1998. £75.00, hardback**

This textbook is intended primarily as a revision aid for surgeons preparing for the MRCS/FRCS exams. This book is already very popular with trainee surgeons because of its short notes and factual content on most of the key points in various core specialties of surgery. This makes it rather heavy going, as the author has attempted to cover most aspects of surgery, a task which is impossible for a book of this size.

In comparison to the 1st edition some important sections have been updated (eg, those on shock, radiotherapy/chemotherapy, and Helicobacter pylori) or added (eg, acid-base balance, laparoscopic and day case surgery, transplantation, HIV, and surgical audit). The new section on the shape of surgical training is useful for trainees but the time and space reserved for the section on nuclear warfare and Gulf war syndrome would have been better applied to improving the poorer sections, eg, those on surgery for gastro-oesophageal reflux (no mention of laparoscopic Nissen), oesophageal cancer, and peripheral vascular disease. Some sections are particularly useful, eg, elective and emergency surgical operations and the examples of clinical short cases. Unfortunately, some of the diagrams are very basic, particularly for the clinical scenarios and physical signs; original photographs would have been appreciated.

Towards the end of the book the author has provided a somewhat biased and outdated reading list. Most of the important clinical trials that candidates are now asked about in postgraduate exams are distinctly lacking. In summary, this book serves as a useful revision aid and purchasers will not be disappointed if they wish to brush up their knowledge a month before their exams. The author deserves some credit for attempting the onerous task of writing a single book for the MRCS/FRCS exams, especially as it is aimed at a market where there are a number of more weighty rival volumes.

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**Pathology for surgeons in training. 2nd edn, D Gardner, D Tweedle, viii + 408 pp. Arnold, 1996. £29.50, paperback**

This book is aimed at surgical senior house officers preparing for the AFRCS or MRCS. The authors are both examiners for the Royal College of Surgeons of Edinburgh. The text is well written and the subject matter is suitably broad without entering into unnecessary detail; this is ideal for what is currently required for postgraduate surgical exams.

There is an emphasis on common diseases, which is appropriate, but many pathologically important diseases are mentioned only briefly. The few illustrations are in the form of well-drawn line diagrams.

The format is strictly alphabetical in the form of an encyclopaedia. This results in a number of anomalies, firstly in that related subjects are widely separated. Cross-referencing attempts to mitigate against this difficulty, but it is incomplete. Secondly, within the disease-related section, the sub-sections are listed on a strictly alphabetical basis rather than in an anatomical or disease-related order.

It is not clear whether this book sets out to be a reference or an easily readable revision text. It is insufficiently detailed for a reference text and its strictly alphabetical layout results in discontinuity, making it very difficult to sit down and read for revision purposes, even though its size and depth would be ideal for this.

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