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Points

Hidden dangers of sliced bread

Dr JOHN McLOUGHLIN and others (St Charles's Hospital, London W10) write: In addition to small bowel and oesophageal perforation, swallowed bread clips may aggravate peptic ulcer symptoms.¹⁻³

A 57 year old man presented with a six year history of stabbing epigastric pain at night relieved by food. Several courses of cimetidine only produced transient relief of his symptoms. Endoscopy showed erosions on the anterior wall and a foreign body, which could not be removed, hooked round a mucosal fold on the posterior wall of the deformed duodenal bulb. At repeat endoscopy for persistent symptoms five months later the foreign body was extracted and found to be a bread clip that had become clipped to the duodenum by its "jaws."

We think that this case supports the mechanism of injury proposed by Bundred and others—that is, the clip grips the bowel wall between its "jaws," causing localised necrosis and eventual perforation, and suggest that the bread clip was responsible for perpetuating his chronic refractory symptoms.

¹ Rivron RP, Jones DRB. A hazard of modern life. *Lancet* 1983;ii:334.

² Bundred NJ, Blackie RAS, Kingsworth AN. Hidden dangers of sliced bread. *Br Med J* 1984;288:1723-4.

³ Sutton G. Hidden dangers of sliced bread. *Br Med J* 1984;288:1995.

Why does time seem to pass more quickly as we grow older?

Professor C R B JOYCE (Ciba-Geigy, Basel, Switzerland) writes: Like Professor Ian Oswald (7 July, p 38), I do not know either. My reasoning, however, has always been the reverse of his: six months may, as he says, be less than 1% of one's total experience, but it eventually comes to represent 5% or more of one's expectations. On his hypothesis, should not time go more slowly? Some people say it does, later on—perhaps after all reasonable expectations have been surpassed and only experience remains.

Massive infusion therapy: a warning

Dr ANNE SUTCLIFFE (Birmingham Accident Hospital, Birmingham B15 1NA) writes: Dr S O Mollestad rightly points out that Travenol dialysis bags may contain more than 1000 ml fluid (4 August, p 290). This may lead to overhydration, which, as he suggests, can be detected by weighing the patient. The patient's weight may, however, vary for other reasons—for example, renewal of plaster of Paris splints or collection of serous fluid in burns dressings. We therefore weigh the dialysis bags before use. Having made an allowance for the weight of the plastic bag, an accurate record of dialysis fluid input can be made.

Unrecognised femoral fractures in patients with paraplegia due to multiple sclerosis

Dr A M K THOMAS (Department of Diagnostic Radiology, Hillingdon Hospital, Uxbridge UB8 3NN) writes: Dr Simon Cocksedge and others (4 August, p 309) rightly point out the dangers of assuming that swelling of a leg is secondary to a venous thrombosis and describe this finding in association with occult femoral fractures. The clinical diagnosis of venous thrombosis may be difficult, and the clinical fractures may also be seen with rupture of a popliteal Baker's cyst.¹ Treatment with anticoagulants is not without risk and clinical diagnosis of a venous thrombosis should be confirmed before starting treatment. Ascending phlebography of the leg shows images of the femoral and iliac veins, and in the patients described the fractures might well

have been shown at the same time that venous thrombosis was excluded.

Modern osmolar non-ionic contrast media and conventional ionic contrast media are both less toxic to the system and also to the vascular endothelium.^{2,3} There have been no reports of thrombosis after phlebography using iohexol, and there is a lower frequency of sensation of heat.⁴

¹ Belch JFF, McMillan NC, Fogelman I, Capell H, Forbes CD. Combined phlebography and arthrography in patients with painful swollen calf. *Br Med J* 1981;282:949.

² Grainger RG. Low osmolar contrast media. *Br Med J* 1984;289:144-5.

³ Laerum F. Injurious effects of contrast media on human vascular endothelium. *Acta Radiol (Stockh)* 1983;366 (suppl):70-1.

⁴ Enge I. Phlebography, survey and present state. *Acta Radiol (Stockh)* 1983;366 (suppl):50-3.

Management of spontaneous pneumothorax

Dr JOHAN WITT and Dr STEPHEN HILL (Wycombe General Hospital, High Wycombe, Bucks HP11 2TT) write: We read with interest Dr J F Riordan's leader (14 July, p 71), and in particular the method of aspiration using a Teflon tube. We have used this procedure successfully on a number of patients, and those who were aware that the alternative is an intercostal tube appreciated it.

Rather than using a 60 ml syringe with a three way tap, we recommend a Maxwell box. This was originally used for refilling artificial pneumothoraces and consists of a metal 200 ml syringe with a built in three way tap, a pressure gauge, and rubber tubing with a Luer fitting. This simplifies the procedure and allows the operator to determine when the air has been aspirated by watching the pressure gauge. This should be considered as first line treatment in uncomplicated pneumothorax and would provide a use for a piece of equipment that has probably been gathering dust on a shelf for many years.

Autoimmune thyroid disease and pregnancy

Dr TERRY F DAVIES (Division of Endocrinology, Mount Sinai Medical Center, New York, NY 10029) writes: The timely leader on autoimmune thyroid disease in pregnancy (16 June, p 1780) was a concise review of this interesting subject. It should, however, also be pointed out that autoimmune thyroid disease may be related to first and mid trimester abortions. We have recently seen two cases of hyperthyroid Graves' disease occurring three and five months after pregnancies were interrupted at 20 and 21 weeks. Since it has been clearly shown that thyroid autoantibody titres may be well suppressed by the end of the first trimester it remains possible that such cases of postabortion autoimmune thyroid syndromes may be of similar aetiology to the postpartum cases. With the ever increasing numbers of pregnancy interruptions performed, physicians should be aware of the possible association.

Four million patients who failed to attend

Dr MARY E CAWLEY (Department of Geography) and Dr FIONA M STEVENS (Department of Medicine, University College, Galway) write: The computerisation of appointments systems recommended as a solution to the failure of outpatients to keep their appointments (14 July, p 107) may not fulfil all the expectations of Dr Brian Mawhinney MP (23 June, p 1928). Factors other than death, recovery, and a lack of "moral responsibility" may impinge on a patient's ability to attend a hospital clinic. Time and cost have

widely differing effects depending on the social and economic circumstances of patients, and assume further importance in the case of hospitals serving a rural or widely dispersed population where patients often travel great distances to attend.

Of a random sample of 325 patients attending general and specialist medical and surgical clinics at the Regional Hospital, Galway, in March 1983, 51% travelled more than 20 miles to the hospital; for 42% attendance required being away from home for more than six hours; and 25% spent IR£10 or more on transport. Postal inquiries to patients who failed to attend the same clinics showed that the main reasons for non-attendance were related to transport, including difficulties of access to public transport and excessive costs. Patients attending the oncology outpatient clinic indicated that rapidly escalating transport costs were imposing a severe financial burden on some families. Thus, it is perhaps necessary to go beyond the mere figures for attendance and non-attendance to recognising that the latter may be due not just to a lack of awareness of the importance of keeping hospital appointments, but to the adverse social and economic circumstances of certain patients.

Dizziness and light headedness

Professor SAMUEL I COHEN (Department of Psychiatry, London Hospital Medical College, London E1 2AD) writes: In "Any Questions?" (4 August, p 311) a question is asked as to the nature of symptoms of "dizziness, light headedness, parasthesiae, etc" and whether the symptoms may be due to a disturbance in circadian rhythm and the answer discusses this point.

The essential point, however, is that these symptoms are common, well known, and typical symptoms of hyperventilation—itsself a symptom of anxiety. It is to the cause of the anxiety that inquiry needs to be directed if such patients are to be helped. Patients who are hyperventilating are often not aware of any disturbance in their breathing, though careful questioning will usually show a disturbance such as excessive sighing or gulping, or may elicit a statement such as: "When I get the tingling, it makes me pant."

Reversible acute on chronic renal failure during captopril treatment

Dr JAMES F BURRIS (Hypertension Research Clinic, Washington DC) writes: The report by Dr Dierik L Verbeelen and Dr Stefan De Boel (7 July, p 20) of reversible acute renal failure superimposed on pre-existing chronic renal insufficiency after starting treatment with captopril is neither surprising nor likely to be a specific effect of captopril. It is well known that renal autoregulation modulates renal blood flow in the presence of hypertension and other haemodynamic alterations. The substantial decrease in systemic blood pressure achieved by captopril in each of the patients reported would necessarily reduce renal blood flow and glomerular filtration, leading to the observed increases in serum creatinine and urea concentrations. Since all three patients had structural changes in the renal vasculature confirmed by biopsy, restoration of renal blood flow by autoregulation would be delayed, resulting in the gradual recovery of renal function which subsequently occurred. We have observed such a transient rise in serum creatinine and urea concentrations after rapid lowering of blood pressure by a variety of antihypertensive agents and regard it as the expected consequence of the haemodynamic change and nothing to do with which drug is used. Antihypertensive treatment should not be withdrawn in such a case, as control of the hypertension is essential to prevent further structural damage to the kidneys. On the other hand, with continued control of the blood pressure renal function generally returns to baseline and may even improve.