EDUCATION INTO PRACTICE

Diagnosing COPD

About 2.8 million people in the UK don’t know they have chronic obstructive pulmonary disease (COPD). Early diagnosis can slow disease progression and reduce hospital admissions. Any patient over 35 years who smokes and has exertional breathlessness, chronic cough, regular sputum production, frequent winter “bronchitis,” or wheeze should have diagnostic spirometry.

How could you ensure that patients at risk are offered spirometry?

To develop this idea further as a quality improvement project, visit BMJ Quality at http://quality.bmj.com.

EDUCATION

ART OF MEDICINE

“He’s taken longer to die than a horse”

A 70 year old dairy farmer with bronchopneumonia and glioblastoma was admitted to the hospice after five days of unsuccessful antibiotic treatment in hospital. His wife had a good understanding of animal physiology. She described his respiratory distress as “double breathing”—a grave sign in horses—and agreed with the medical team’s decision to stop treatment. But she was concerned that he took much longer to die than her animals and thought that he had been “starved to death.” She saw no-one offer him food or drink and said that nobody had told her that she could do so.

In 2012 suggestions that the Liverpool care pathway led to malnutrition, dehydration, and premature death led to media outcry. An external review advised replacing the pathway with a “personalised end of life care plan.” The Leadership Alliance for the Care of Dying People has outlined five care priorities, all based on communication with patients and families. The alliance states that food and drink must continue to be offered for comfort, but the medical team failed to tell the family this. It highlights the importance of communicating not only what dying patients can’t do or have, but also what can be provided. It also underlines the importance of exploring each family’s understanding of the dying process, as their employment or life experiences may be unique. Oral food and fluids must not be viewed as treatments but as comfort measures that should, if possible, be enjoyed by all.

Fay Murray-Brown specialty trainee year 4, palliative medicine, Hospiscare, Exeter, UK

Patient consent obtained from spouse after patient’s death.

Cite this as: BMJ 2015;351:i4590

We welcome contributions to this column via our online editorial office: https://mc.manuscriptcentral.com/bmj

CLINICAL UPDATES

Routine preoperative tests for elective surgery

No tests should be routinely recommended before minor surgery such as excision of a lesion say new NICE guidelines aimed at reducing waste. If a patient is at risk of acute kidney injury or has not had an electrocardiograph (ECG) in the past 12 months, kidney function blood tests or ECG should be considered before minor surgery. For intermediate surgery, such as a haemia repair, only patients of ASA 3 or ASA 4 physical status should routinely have an ECG or kidney function tests. For other tests, such as a full blood count, the guidelines describe the situations when these should be considered.


Quality improvement: training for better outcomes

A new report from the Academy of Medical Royal Colleges recommends incorporating a set curriculum on quality improvement into all stages of doctors’ training. Quality improvement should be integral to all medical and non-medical job descriptions and appraisals. Career recognition should be given to achievements in quality improvement and doctors at all levels should have access to quality improvement training.

http://www.aomrc.org.uk/

Chronic wound dressings

The range of dressings available for chronic wounds is legion. Primary care spending on advanced wound dressings (alginate, film, foam, hydrocolloid) and antimicrobial dressings (iodine, silver, honey) totals £110m/year. In the absence of clinical grounds the least costly dressing that meets the required wound characteristics in terms of size, adhesion, and fluid handling should be considered says recent advice from NICE. In a review of current evidence NICE found a paucity of evidence to support the use of advanced dressings over conventional ones.


Cite this as: BMJ 2016;353:i2010
Palliative care in patients with heart failure

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This is an edited version of the state of the art review, full version is on the bmj.com
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Heart failure is a syndrome of cardiac dysfunction characterized by dyspnea, fatigue, and fluid retention.1

Morbidity is high, hospital admission is common, median survival is less than five years, and the disease places great demands on patients, caregivers, and healthcare systems.6

Most contemporary data from developed nations indicate that the incidence of heart failure has plateaued, or even decreased.3 16 The combination of increasing prevalence with stable incidence suggests patients are living longer with symptomatic disease, which has obvious implications for palliative care needs.

WHAT YOU NEED TO KNOW

- Palliative care is designed to complement traditional heart failure care through its focus on communication, shared decision making, and advance care planning
- Patients tend to follow a progressive, albeit non-linear, decline in health related quality of life
- Palliative care has clear applications to heart failure, particularly in advanced disease but also in earlier stages
- Greater integration of palliative care has the potential to handle clinical uncertainty and improve communication
- Considerable effort is needed to improve the evidence base for palliative care interventions, develop better decision aids and improve communication training

Distribution of adults in need of palliative care at the end of life by disease.

*Adapted, with permission, from the World Health Organization8

SUMMARY

Palliative care has applications across the stages of heart failure, including early in the course of illness, often in conjunction with other therapies that are intended to prolong life. The incorporation of palliative care into the management of heart failure has been suboptimal for several reasons: uncertainty in the disease trajectory, failure to reward communication between healthcare providers and patients, siloed care, lack of knowledge, overlay of comorbidity and frailty, life saving devices with complex trade-offs, and a limited evidence base. This review will summarize the current literature on the emerging role of palliative care in patients with heart failure and the challenges and opportunities for its integration into routine care.

Role of palliative care in heart failure

Because of the progressive, chronic, but unpredictable course of heart failure, palliative care can help meet the needs of patients, families, and healthcare providers. For example, patients with heart failure would prefer to die at home, yet most still die in hospital. Consultations with palliative care providers have shown an increase in the likelihood of death at home.38

Experts and the public are increasingly calling for the expansion of palliative care to patients with heart failure (fig 1). The 2013 American College of Cardiology/AHA guidelines on the management of heart failure include a class IB recommendation that palliative and supportive care is effective for patients with symptomatic advanced disease to improve quality of life.1

Specific needs of people with heart failure

Symptoms, functional limitations, and quality of life

The most common symptoms of heart failure are pain, breathlessness, fatigue, and depression. Most patients describe at least one symptom as burdensome.33 When heart failure nears end stage, it has one of the largest effects on quality of life of any advanced disease.47 In a US study of 60 patients with symptomatic heart failure and 30 with advanced lung or pancreatic cancer, those with advanced heart failure reported greater symptom burden and depression as well as lower spiritual wellbeing than those with advanced cancer.39

Multimorbidity

Multimorbidity contributes to the range of symptoms, complicates management, and can alter prognosis. On average, patients with heart failure have 4.5 comorbidities.48 The presence of additional comorbidities also leads to polypharmacy, which increases patient and family burden.

Frailty is a biologic syndrome characterized by a decline in overall function and loss of resistance to stressors.50

16 April 2016 | the bmj
Clinical course of heart failure with associated types and intensities of available therapies and incorporation of palliative care. Red line (clinical course): patients tend to follow a progressive, albeit non-linear, decline in health related quality of life; this course can be interrupted by sudden cardiac death caused by arrhythmia or can end in a more gradual death from progressive pump failure. Yellow line (traditional care): at disease onset, multiple oral drugs are prescribed for cardiac dysfunction or comorbidities (or both). As disease severity increases, the intensity of care may also increase, with intensification of diuretics, addition of an implantable cardioverter defibrillator or cardiac resynchronization therapy for those eligible, and increasing interaction with the medical system through ambulatory visits and hospital admissions, until standard therapies begin to fail (transition to advanced heart failure). Purple line (palliative care): palliative therapies to control symptoms, improve quality of life, and enhance communication are relevant throughout the course of heart failure, not just in advanced disease, working together with traditional therapies designed to prolong survival. The critical transition into advanced heart failure from the medical perspective is often followed by a transition in goals of care from the patient and family perspective, when palliative therapies may become the dominant treatment paradigm (for the majority of patients, in whom transplantation and mechanical circulatory support are not an option). Clinicians must recognize the transition to advanced heart failure so that therapeutic options can be considered in a timely fashion and patients can proactively match medical decisions to clinical realities. CHF=chronic heart failure; MCS=mechanical circulatory support *Adapted, with permission, from the American Thoracic Society

Several studies have shown that frailty is more prevalent in people with heart failure than in the general elderly population.

Palliative care interventions
A palliative care specialist is not needed to prescribe many of the interventions; most primary care or cardiology clinicians can provide these services.

Dyspnea refractory to hemodynamic interventions (diuretics, afterload reduction, inotropes) can be treated with low dose opioids and benzodiazepines. Non-pharmacologic management includes using a fan to provide cool air to the face, breathing training, and anxiety management.

There are few data supporting specific interventions for patients with heart failure. Trials on the use of opioids for treating dyspnea in heart failure have been small and the results have been conflicting in terms of effectiveness, although opioids did seem to be safe. The Sertraline Against Depression and Heart Disease in Chronic Heart
Failure (SADHART-CHF) trial of 469 patients found no significant difference in depression or cardiovascular status in the treatment group compared with placebo, and sertraline was well tolerated. In the Depression and Self-Care of Heart Failure trial of 158 patients with heart failure, cognitive behavioral therapy plus usual care was compared with usual care alone. The primary outcome was the Beck depression inventory score at six months, and the self care of heart failure index confidence and maintenance subscale scores were co-primary outcomes. Cognitive behavioral therapy was effective in the treatment of depression in patients with heart failure compared with usual care (Beck depression inventory score 12.8 (standard deviation 10.6) v 17.3 (10.7); P=0.008), but it did not influence self care.

**Integrating palliative care into heart failure care**

Uncertainty in the heart failure disease trajectory

Heart failure often follows an unpredictable course, with periods of stability interrupted by exacerbations, sometimes ending in sudden death or competing non-cardiovascular illness, but most typically culminating in irreversible pump failure. Acute exacerbation often represents a temporary reduction in health status but can be a terminal event; at the time of presentation it can be nearly impossible to anticipate the patient’s response to therapy and eventual disposition.

**Poor communication**

End of life discussions are often time consuming and require navigating the complex needs of patients and families. Unfortunately, cardiology providers have reported an unwillingness to discuss information such as poor prognosis.

Avoidance of difficult discussions about end of life is probably exacerbated by a lack of training in palliative and communication techniques.

A qualitative study of 20 patients with advanced heart failure from Canada aimed to understand patient preferences of prognosis communication. Patients expressed a desire to discuss their prognosis earlier in the disease process and preferred a physician to initiate these discussions. Because heart failure is a chronic process with an unpredictable trajectory, early and iterative solicitation of values, goals, and preferences is necessary to guide the range of treatment options and decisions. It is important to revisit these areas.

**Silos of care**

An increasingly specialized medical system in which inpatient and outpatient services are separated, often with non-communicating electronic health records, has created a fractionated system that works against the integrated holistic approach to management that is at the center of palliative care. A UK survey study found that only a little over half of palliative care physicians and nurses reported some form of collaboration with cardiology.

**Evolving approaches**

**Primary palliative care and team based care**

Despite these challenges, a team based approach is essential to the care of patients with heart failure and is potentially facilitated by the integration of palliative care.

In the early phase of the disease, a general practitioner or cardiology provider can lead the team with formal palliative care consultation only as needed. Non-palliative care specialists should be empowered by palliative care providers and through skills training to practice primary palliative care with all patients. In end stage heart failure or at the time of major medical decisions (such as consideration of LVAD implantation), trained palliative care providers may take on a more central role in coordinating care. To decrease patients’ confusion and prevent feelings of abandonment, improved communication around these transitions is essential. One solution in advanced disease may be to appoint a member of the cardiology team to provide the link with palliative care. Several studies have reported effective collaborations involving a heart failure nurse or case manager who liaises between the two teams.

**Advance care directives and preparedness planning**

For patients, advance care directives provide an avenue to express their wishes about life sustaining treatments, usually to withhold or withdraw, in the event of a terminal condition. For providers, advance care directives can help when assessing patients’ values, goals, and preferences to facilitate concordant treatment decisions.

Ideally, advance care planning should start early in the disease process and progress iteratively through the course of the disease. Moving advance care planning upstream involves preparedness planning. Advance
Shared decision making and decision support

Shared decision making puts patient centered care into practice. It involves both patients and providers, with the ultimate goal of ensuring that a patient’s values, goals, and preferences guide informed decisions. Shared decision making recognizes that there are often complex trade-offs when taking medical decisions and it fulfills the ethical and legal mandate to fully inform patients of all risks and benefits of a treatment. This is particularly true in heart failure, where several medical decisions (such as whether to insert a LVAD) are preference sensitive owing to their high risk-high reward nature. The tenets of palliative care are fundamentally patient centric, and the specialty places shared decision making and related patient-provider communication at the forefront of management.

Decision aids are tools designed to facilitate shared decision making and patient participation in healthcare decisions. They are not substitutes for conversations with healthcare providers but tools to help frame the discussions and inform patients of their options. A recent systematic review of tools used to promote shared decision making in critically ill patients showed that the use of decision aids improved knowledge and awareness of treatment choices. Decision aids have been developed for some heart failure treatments, including ICDs and LVADs (https://patientdecisionaid.org/).

Expanding the evidence base

Little evidence is available on the direct outcomes of palliative care in patients with heart failure, including how best to incorporate this specialty. Systematic and consistent evidence is lacking worldwide. This evidence is crucial because of the important cultural and environmental differences in the way palliative care services are provided. Physician (or Medical) Orders for Life-Sustaining Treatment (POLST/MOLST) programs, the Institute for Healthcare Improvement conversation project, the efforts of the Coalition to Transform Advanced Care, and the “five wishes” advance directive of the Aging with Dignity organization are widely used despite the absence of compelling evidence that they improve patient outcomes.

The Palliative Care in Heart Failure (PAL-HF; NCT01589601) trial is a prospective, controlled, unblinded, single center study of an interdisciplinary palliative care intervention in 200 patients with advanced heart failure estimated to have a high likelihood of mortality or readmission. The six month PAL-HF intervention focuses on physical and psychosocial symptom relief, attention to spiritual concerns, and advanced care planning. Secondary outcomes include impact on anxiety, depression, spiritual wellbeing, caregiver satisfaction, and cost and resource utilization. The results of this trial, expected after July 2016, will help provide further data on the usefulness of palliative care interventions in patients with heart failure.

Similarly, the Collaborative Care to Alleviate Symptoms and Adjust to Illness in Chronic Heart Failure (CASA; NCT01739686) trial is expected to be completed by December 2016 and will provide randomized data on whether an intervention to improve symptoms and quality of life by integrating palliative and psychosocial care into chronic care is feasible and improves patient outcomes.

Evidence on how and when to incorporate palliative care into the management of heart failure should improve outcomes. Integration of palliative care and heart failure

Care directives have traditionally focused on end of life care, while preparedness planning focuses on preparing for any adverse event. Preparedness planning has been shown to improve attitudes and increase completion of advance care directives in patients with heart failure. The concept of preparedness planning is often combined with a palliative care visit as the first step to the ultimate completion of advance care directives. The focus of preparedness planning is specific to the individual patient’s situation, and it focuses on respecting patients’ beliefs and preferences.

It is not clear who should deal with these matters. Ideally, the patient’s primary care provider or cardiologist should initiate these discussions. To ensure these discussions happen over time, the AHA has proposed an “annual heart failure review” to encourage iterative discussions about goals of care and as a way to improve advance care planning (fig 2).

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Evidence on how and when to incorporate palliative care into the management of heart failure should improve the overall care for these patients (fig 3).

Cite this as: BMJ 2016;353:i1010
Find this at: http://dx.doi.org/10.1136/bmj.i1010
Self harm and the emergency department

Clinicians’ reactions to people who self harm can make all the difference

I speak quietly at the emergency department reception desk, but much of the waiting room can still hear. There isn’t an easy way to announce in a room full of strangers that you’ve hurt yourself, again. In case anyone listening is in doubt, then comes the question: “Did you do this to yourself?”

Self harm is one of the most common reasons for general hospital admission. People who present to the emergency department with self harm have a relative risk of suicide 49 times greater than the general population, and up to 100 times greater in the next year.

Emergency department clinicians have saved my life more than once. But self harm often comes with stigma, and our interactions are uneasy. I’m a “frequent flyer” (their term) and can be met with extremes. From the most thoughtful, compassionate care to frustration, blame, judgment, and shaming.

I don’t expect the emergency department at 3 am to provide a solution—I’ve been self harming for 30 years and there isn’t a quick fix—but there are things you can do to help. Ensuring that the cause of the injury doesn’t affect the quality of care is important. When I self harm, my injuries are serious—yet I’m rarely offered analgesia. Offering analgesia shows that you think the person does not deserve to hurt. I’ve sometimes heard, “but I thought you liked pain,” and been told how expensive dressings are.

Small things can help

Many people who self harm have experienced trauma. Healthcare environments can trigger associations with that trauma and be frightening. If the person is able to tell you, ask what would help them to feel safe—for example, not being made to wear a gown unless it is clinically essential, or being offered

What you should know

- Don’t let the cause or frequency of harm affect care; assess pain and offer analgesia
- Avoid “all or nothing” approaches, where turning down suggested treatment means being turned away
- A lack of control can contribute to self harm; involve patients in decisions and facilitate self care
When I self harm, my injuries are serious—yet I’m rarely offered analgesia

the opportunity to sit on a chair rather than a trolley or bed.

Self harm can help some people find control in a desperate situation where there is none, so it’s important not to take more control away from them or to dismiss them. For example, I was told by clinicians that there is “no point in seeing me” if I am “refusing treatment” when I was too fearful to accept admission by the plastics team; but I could have managed dressings, emergency wound care, and outpatient review if it had been offered. I appreciate being offered gold standard treatment, but if sometimes I cannot accept parts of it please don’t walk away. Work with me to find the best treatment I can tolerate.

Self harm is often a private act

Even though self harm has led to many hospital admissions, including time in intensive care, few of my work colleagues, friends, or family know. For some people, the emergency department is the only place where their injuries will be seen by another person. Think about what each stage of the assessment and treatment process requires of the person and the impact it might have. Maximise privacy where you can, closing curtains during examination, and replacing temporary dressings after triage.

There are as many reasons for self harming as people who self harm, but a common theme is that it stems from a place where there is psychological pain. So making people feel worse about what they’ve done is unlikely to make them stop self harming. It may increase the risk of repetition or stop people seeking help.

By contrast, people who treat me with dignity and compassion help me more than they realise.

WHEN YOU NEED TO KNOW

- Elbow pain on specific movements suggests tendonitis, and tennis elbow is the most common
- Optimal treatment of tennis elbow is unclear, but pain control, work modification, physiotherapy, and orthotics may help to reduce symptoms
- Corticosteroid injections provide better pain relief at six weeks, but by six months the symptoms in this group are no better and sometimes worse

A 50 year old supermarket cashier complains of progressive elbow pain for the past two weeks. It is hard for her to scan heavy items at work and to lift saucepans at home.

Lateral elbow pain is common (population prevalence 1-3%). It is usually assessed and managed in primary care, and the incidence of lateral elbow pain in general practice is 4-7/1000 people a year. Interrupted sleep, inability to use the hand, and psychological ill health (anxiety or depression) are associated with problems functioning at home or work.

Progressive elbow pain

Alexis Descatha,1 2 Thomas Despréaux,1 2 Ryan P Calfee,3 Bradley Evanoff,4 Olivier Saint-Lary5 6

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HOW PATIENTS WERE INVOLVED IN THIS ARTICLE

Article predates our patient partnership changes, and so no patients were involved.

CPD/CME

0.5 CREDIT

Fig 1 | Location of pain at different sites of the elbow (upper postero-lateral view, during the provocative manoeuvre of lateral epicondylitis, applying resistance against wrist dorsiflexion). Red area = lateral epicondylitis, purple area = medial epicondylitis (partial), yellow area = radial tunnel nerve entrapment, aqua area = joint disorders.

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This is part of a series of occasional articles on common problems. The BMJ welcomes contributions
Consider examination for pathology of the shoulder, rotator cuff, and neck if the diagnosis is not clear.

What you should do

Lateral epicondylitis (tennis elbow) is the most common cause of persistent elbow pain, responsible for two thirds of cases presenting in general practice. It will improve spontaneously in around 80–90% of people over 1–2 years. Analgesia, work modification, and physiotherapy may help to manage symptoms but are not known to alter the long term prognosis.

Systematic reviews and meta-analysis have evaluated treatment of tennis elbow, but the low quality of included studies and the lack of long term follow-up limit any conclusions. However, accepted practice is:

- Offer short term regular paracetamol. Non-steroidal anti-inflammatory drugs (NSAIDs) may help but should be reduced as soon as possible. A recent Cochrane review concluded that NSAIDs (oral and topical) are ineffective in this condition in the long term while increasing side effects (abdominal pain). 7
- Advise a short cessation of aggravating sports and manual work while maintaining activity. Physiotherapy focuses on maintaining motion and strengthening exercises (fig 2), possibly with the aid of wrist cock-up brace or epicondylar counterforce (elbow) brace.
- In the past corticosteroid injections were offered. For lateral epicondylitis they provide temporary (six weeks) pain relief which may be superior to that provided by NSAIDs and physical therapies. 2 By six months, however, patients treated with steroid injection report either the same or more symptoms than those who did not receive an injection. 8
- Suggest that the patient tries to reduce instances of forceful grip, wrist extension, and elbow flexion, and duration of such movement, in work and in sport (recommended by the American College of Occupational and Environmental Medicine practice guidelines with an “insufficient level of evidence” based on observational studies). 7 This may be supported by instructions for the employer, such as to mix work patterns, increase the number of rest breaks, and, if feasible, to change the way to manipulate objects with forceful gripping and awkward wrist posture.
- Advise patient to return in case of increasing pain, difficulty in sleeping or in functioning well at home or work, or unusual persistence (>6–12 months). In such cases, re-examine the patient and possibly refer to a specialist from rehabilitation or surgery (immediately in the case of initial severity). 4
- Reassure the patient that it is unlikely to result in long term disability and does not cause arthritis.
- Imaging and referral should be performed in case of unusual pain location or severity, or associated symptoms, and when needed to rule out an alternative diagnosis (bone and joint disorders, nerve entrapment).

Competing interests: None declared.

Cite this as: BMJ 2016;353:i1391
Find this at: http://dx.doi.org/10.1136/bmj.i1391
CASE REVIEW A man with a short history of lower back pain

A previously fit and well 69 year old man presented to his general practitioner with a four week history of lower back pain. He had no history of trauma, took no regular drugs, was an ex-smoker, and did not drink alcohol. Physiotherapy, sought privately, had provided no benefit. His GP prescribed painkillers and reviewed him two weeks later, at which point, with no improvement in symptoms, spinal radiography was organised. Radiography showed multiple compression fractures of vertebrae T11-L2 (figure; arrows).

The GP arranged blood tests and referred the patient to hospital for assessment. On further questioning, he had recently lost weight and had loss of appetite. Pallor was noted on examination. There were no neurological findings (in particular, no signs of spinal cord compression) and other systems examinations were normal. Rectal examination showed a smooth, enlarged prostate, with normal anal tone and sensation.

Blood tests showed normocytic anaemia (haemoglobin 99 g/L (reference range 130-180), mean cell volume 95 fl (80-100)), and normal white cell and platelet counts. A renal profile was normal, bone profile showed protein 86 g/L (60-80), albumin 35 g/L (35-50), globulin 51 g/L (22-43), alkaline phosphatase 163 U/L (30-130), adjusted calcium 2.74 mmol/L (2.20-2.60), and phosphate 1.64 mmol/L (0.80-1.50). Imaging studies comprised whole spine magnetic resonance imaging (MRI); computed tomography of the thorax, abdomen, and pelvis; and a skeletal survey.

1 What is the diagnosis?
2 What additional investigations would aid diagnosis?
3 What complications may arise?
4 How should this patient be managed?

Submitted by Alison Edwards, Preethi Nalla, and L D Premawardhana

CASE REVIEW An 81 year old woman was referred to haematology with a six month history of fever, 7 kg weight loss, night sweats, and abdominal distension. She was otherwise fit and well; she had no travel history of note and did not smoke or drink alcohol.

On examination, she had massive splenomegaly palpable to the level of the umbilicus. The examination was otherwise normal and she had no palpable lymphadenopathy in the cervical, axillary, or inguinal regions.

Blood results showed haemoglobin 119 g/L (reference range 123-167), white blood cell count 68.0×10^9/L (3.5-11), lymphocytes 53.0×10^9/L (1.0-3.0), neutrophils 4.1×10^9/L (2.0-7.0), monocytes 6.8×10^9/L (0.2-1.0), and platelets 134×10^9/L (150-410). Urea, creatinine, and liver function tests were normal. A peripheral blood smear was performed (figure). Flow cytometry showed that 60% of total peripheral blood leucocytes were CD19, CD20, CD22, CD79b, CD11c, and CD103 positive surface immunoglobulin light chain λ restricted B cells, which were negative for CD5, CD10, CD23, and CD123. The remaining cells expressed a phenotype for normal and reactive mature lymphocytes.

Molecular testing confirmed these cells were negative for BRAF V600E mutations. On the basis of the peripheral blood smear and flow cytometry results what is the diagnosis?

Submitted by Selina J Chavda and Claire Dearden

Spot diagnosis

Interesting case of lymphocytosis and splenomegaly

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Submitted by Selina J Chavda and Claire Dearden

Patient consent obtained.

Cite this as: BMJ 2016;352:i1227

Find this at: http://dx.doi.org/10.1136/bmj.i1227
A red eye from carotid stenosis

A 66 year old man presented with a painful red right eye. He had right eye uveitis and was treated with steroid drops. At monthly review he had cataracts and new vessels on the iris. A bruit was heard over the right carotid only. Computed tomography angiography showed occlusion of the right common carotid artery (arrow). He has ocular ischaemic syndrome owing to right carotid occlusive disease. Symptoms are loss of vision, pain, and amaurosis fugax. Uveitis may be the first presentation of carotid occlusion and careful examination of the iris for new vessels is mandatory.

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Patient consent obtained.

Cite this as: BMJ 2016;352:i364

Don’t just sit in front of the TV

In 2013, 68% of 2034 Australian adults in an online survey thought it was appropriate to limit children’s screen time to the recommended ≤2 h/day (BMC Public Health doi:10.1186/s12889-016-2789-3). But most adults themselves spent >2 h watching TV and using the computer at home on work days (66%) and non-work days (68%). Grown-ups, honestly.

Assortative mating and mental illness

The “madness-runs-in-families” trope began in genealogies and novels and then transmuted into modern genetics. But family patterns of psychiatric illness can be complicated by the tendency for people with a wide variety of psychiatric diagnoses to meet and show “assortative mating.” Using one case to five controls in a whole population Swedish database, investigators found non-random mating in psychiatric populations within 11 specific disorders and across the spectrum of psychiatric conditions (JAMA Psychiatry doi:10.1001/jamapsychiatry.2015.3192).

Sleeping on the kids’ ward

Lots of parents end up staying overnight with their children on paediatric wards, and 17 of them describe their travails in a qualitative study in Arch Dis Child doi:10.1136/archdischild-2015-309458. Narratives like these are key to simple service improvement (such as reducing noise) and should be used routinely in all health settings.

Treatment resistant schizophrenia

In a large Danish observational study, “treatment resistant” schizophrenia was defined by treatment with clozapine or hospital admission after two different drug treatments (Lancet Psychiatry doi:10.1016/S2215-0366(15)00575-1). Of 8044 patients, 1703 (21%) fulfilled these criteria during a median follow-up of 9.1 years. They showed a cluster of predictive factors that differed from classic risk factors for schizophrenia, leading the authors to wonder if treatment resistant disease might be a distinct subtype of schizophrenia and not just a more severe form.

Bashed brain biomarker

The traumatised brain leaks glial fibrillary acidic protein (GFAP) and ubiquitin C-terminal hydrolase L1 (UCH-L1) into the circulation. An American study of 1831 blood samples from 584 patients drawn in the week after head injury shows how these markers change over time and correlate with computed tomography findings (JAMA Neurol doi:10.1001/jamaneurol.2016.0039). But it’s not clear how this helps clinical management, and press hype about this “simple blood test” is taken apart in an article in Health News Review (http://bit.ly/1SaQRMM).

Wine that gladdens the heart of man

The earliest writings to celebrate the happy effects of wine were hymns to the Sumerian goddess Ngeshtin-ana, followed 2000 years later by Psalm 104 v 15. Another 3000 years later, the journal Alcohol and Alcoholism surprisingly joins the refrain (doi:10.1093/alcald/awg016). On the basis of a random sample of the Finnish population it states: “Consumption of wine with meals was associated with high socioeconomic status and high subjective well-being … Potential unknown confounders may exist, but the results underline a link between subjective well-being and drinking wine with meals.”