Letters to the editor

References


Response

Editor – We would like to thank our colleague for his thoughtful comments and would like to respond point by point.

1. We regret not mentioning the references for the Diagnostic
Statistical Manual (DSM) criteria. Although both clinicians and researchers can be expected to be familiar with the form
call defined DSM criteria, it was an error to not put the reference in our reference list. We agree with the fact that acute
onset does not mean ‘1 day’, as we adhere to the DSM
criteria. Our table did mention ‘acute’ without defining it.
We believe that the speed of onset is dependent on the cause
of delirium, with postoperative delirium taking around 2
days and sepsis just a few hours.

2. The underdiagnosis of delirium is a frequent problem and
might be partly related to the fluctuation of symptoms
throughout the day. Missing delirium symptoms could prevent
appropriate treatment of the underlying disorder
of the patient and could be seen as a medical omission. We
agree there is no need for the admission of patients with
behavioural and psychological symptoms of dementia
(BPSD) to hospital, but this diagnosis is not always easy for a
general practitioner (GP) with limited time for observation.

3. Our manuscript aimed to give an overview of delirium
by summarising the important aspects and presenting
some new insights based on important papers of the recent
years. Our review is not exhaustive, and more important
highlights have been published recently. We believe the
meta-analysis of Witlox has the highest level of evidence on
survival and delirium, and we expect delirium researchers
of the included studies would have been able to discriminate
well between BPSD and delirium.2 The confusion
assessment method (CAM) is not the ‘gold standard’ test
for delirium. The more strict the definition of delirium
(according to DSM criteria), the stronger the association
with mortality can be expected. This may be an explanation
for the lack of association between CAM positive delirium
and survival in the Australian cohort.

4. We agree that testing of hearing is important for all diseases
that use cognitive testing – not just for delirium, but also
dementia and depression. Importantly, hearing loss is also
a risk factor for delirium, and this is often underreported.
Additionally, there are other important impairments
that can influence performance on cognitive functional
testing, such as visual impairment and language problems.
In general, one could expect that healthcare workers and
researchers involved in delirium research take possible
impairments into consideration.

Pulmonary embolism in Bradford, UK: role of end-
tidal CO₂ as a screening tool

Editor – I read with interest Riaz and Jacob’s article on using
end-tidal CO₂ as a screening tool for pulmonary embolism
I would like to point out that the estimates of the performance of
D-dimers and Wells’ score presented in the article, including the
area under curve (AUC) figures, are severely biased as a positive
D-dimer or high Wells’ score were used to select patients for
inclusion in the cohort in the first place. For example, the reported
AUC of 0.52 for the Wells’ score should be interpreted as the ability
of different values above the threshold to discriminate between
patients with pulmonary embolism (PE) compared to those
without or, to put it otherwise, whether a threshold different to the
current one would be more appropriate. Similarly, the reported
performance of end-tidal carbon dioxide (ETCO₂) applies only
to patients preselected for a computed tomography pulmonary
angiogram (CTPA) on the basis of a positive D-dimer test or
elevated Wells’ score, but cannot be assumed to apply to the general
population of patients presenting to the hospital with suggestive
respiratory symptoms.

Funding of medical education: the need for transparency

Editor – In their reply to Dacre and Walsh’s piece on medical
education Pereira Gray and Harding (Clin Med April 2014 pp
212) could have gone further. Were the providers of clinical
attachments – whether hospitals or general practices – to tender
competitively for contracts to take students it is our belief that,
not only would the price charged more accurately reflect the
cost of providing the teaching, but innovation in the way that
teaching was provided would flourished too.

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