

Letters

WHAT IS THE FUTURE OF MINOR SURGERY IN NORTHERN IRELAND

Editor,

The NHS here faces challenging times with significant disinvestment over the next few years. The arrival of commissioning will provide an opportunity to continue to provide the best service we can within financial constraints. Now, more than ever, we need to be looking at who provides what service and where.

Minor surgery has always been provided in primary care. Changes in the GP contract in 1990 and 2004 have seen an increase and diversification of procedures. Everything from skin tag excision to hernia surgery is offered at primary care centres throughout the UK.

Evidence for the quality of minor surgery in primary care seems to be heavily influenced by who has undertaken the study. Two major recent studies reached opposite conclusions. Prof Primrose, a surgeon found outcomes to be better in hospital and Professor Murchie, a GP found better care in primary care. NICE revised its skin cancer guidelines in 2010 after its initial recommendations, written nearly entirely in secondary care, were rejected by GPs who had been effectively excising low risk BCCs and SCCs for years.

Community surgical services are delivered by a wide-ranging group of clinicians. Some are members or fellows of the royal college of surgeons and others have limited surgical experience. Indeed the RCGP does not include minor surgery as a core competency for GPs. This heterogeneity of providers has led to some concern both within general practice and from our hospital surgical colleagues.

Some GPs are also working in inadequate facilities for the procedures they are providing. It is likely that the Care Quality Commission will curtail some practitioners when GP surgeries face licensing in the next few years.

We need to look again at community based surgical procedures and standardise facilities and training. The family planning model is one I feel we could borrow from. Family planning can be delivered from specially equipped centres staffed by clinicians with a special interest. It is based in primary care but works closely with both GPs and hospital consultants. A relationship builds up overtime with primary and secondary care. There is appropriate clinical governance so Consultants and GPs alike are confident in the service.

A similar care pathway could be developed for community surgery. Discussions need to be had between stakeholders as to what procedures could be offered and by what providers. In the Grampian region of Scotland they have appointed a community based Consultant Surgeon to oversee this process.

In Northern Ireland there are no competency criteria for GPs providing minor surgery and no requirement for audit of procedures that are done. There are no established training pathways for GPs to provide surgical services. There is also

no regulation of premises from which the service is provided. There is little support from hospital colleagues for our minor surgery activity.

Now is the time to tackle the issue of primary care surgery in Northern Ireland. In Great Britain there are national audits on primary care vasectomy, carpal tunnel and other surgical procedures being collated. We need to become more pro-active and look at our own services or risk getting left behind with outdated, expensive and potentially dangerous care pathways.

The author has no conflict of interest

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ARE WE PROVIDING THE MULTIMODALITY TREATMENTS ADVOCATED WITHIN CURRENT GUIDELINES WHEN MANAGING PATIENTS WITH LOWER BACK PAIN?

Editor,

Low back pain (LBP) is a common disorder, affecting around one-third of the UK adult population annually. Usually, this is a benign, self-limiting disorder not requiring professional advice or specific treatment.¹ Around 20% of people with LBP will consult their GP.² Annually LBP in the UK costs about £10,668 million.³

TABLE 1:

Percentage of individual modality uptake in patients

Modality	%
Physiotherapy	82
Chiropractor/ Osteopath	72
Acupuncture	12
Combined Physical & Psychological Therapy	0
NHS Documentation	18

The National Institute of Clinical Excellence (NICE) published guidelines in 2009 on the 'Early management of persistent non specific lower back pain' outlining the initial care of LBP using current and complementary treatment modalities.

Recommendations include a multidisciplinary approach employing manual therapy with spinal manipulation or massage, physiotherapy with a structured exercise programme, and acupuncture. Information literature is recommended to encourage patients' involvement in their care. They suggest referral to a combined physical and psychological treatment programme, which is not available in all regions.

We constructed a questionnaire for patients attending a single spinal surgeons outpatient department over a 2-month period, with a history of non-specific LBP of less than 12 months.

Age, gender and duration of symptoms were determined, together with all treatment options/information provided to patients. 50 consecutive patients were questioned. The mean duration of LBP was 8.7 months. Average age was 45 years. The percentage of patients attending each modality is shown in table 1. No patients received all the treatment modalities, and 4% had failed to receive any prior to consultation. 78% had received two modalities at time of referral.

The NICE guidelines provide evidence-based best practice for managing acute persistent LBP. They offer a strategy for primary care management prior to spinal outpatients referral. Surgery is considered only after other modalities have failed. Appropriate management of this complex patient group has the potential to minimize those with disabling long-term back pain, and reduce the personal, social and economic impact of LBP.²

NICE identifies various multidisciplinary treatments including promoting patient self-management through advice and information. They aim to reduce the impact on a patient's day-to-day life, even if the pain cannot be relieved completely.² Only 18% of patients had received written information or advice. NICE advise referral to a combined physical and psychological treatment programme but such a service is not provided by healthcare trusts within Northern Ireland.

TABLE 2.

Percentage of combined modalities offered to patients

Total number of modalities utilised	% of patients undertaking
5	0
4	2
3	16
2	52
1	26
0	4

NICE recommends acupuncture. Systematic reviews have found it a useful adjunct to conventional care.⁴ In this cohort, only 12% received acupuncture. Availability of NHS acupuncture is limited in our region.

Referral to a surgeon may be for advice and reassurance, and the assumption that all patients being referred should have undertaken all modalities would be unfair. Referral pathways may reflect longstanding traditional routes, possibly explaining the large percentage receiving physiotherapy compared to complementary therapies.

Despite a full complement of treatments there will always be patients refractory to conservative management who may benefit from spinal outpatients referral. Further studies may determine whether greater awareness and adherence to such guidelines improves clinical outcome. At present the adherence to the guidelines is inconsistent. New guidance must be effectively disseminated among healthcare professionals to offer patients the best evidence based care and ultimately reduced the morbidity and economic impact of

the condition. Treatment options proposed need to be available to the primary care physician, perhaps explaining why, within our region, such guidelines cannot be fully observed.

The author has no conflict of interest

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HOME TREATMENT: CHANGES TO MENTAL HEALTHCARE IN NORTHERN IRELAND

Editor,

During episodes of acute illness people with complex and enduring mental disorder will require intensive monitoring, support and treatment to help return them to stability.

With the progressive deinstitutionalisation of psychiatric services to the community, episodes of acute illness are being increasingly managed without hospital admission. The establishment of Home Treatment/Crisis Response (HTCR) mental health teams has allowed alternatives to be offered. In areas with HTCR team intervention there have been reduced rates of hospital admission^{1,2}, reduced lengths of in-patient stay¹ and higher levels of satisfaction among users and families reflected by reduced loss to follow-up³.

In 2007 the Southern Trust established the first Home Treatment Service to exist outside of Belfast, only the second of its kind in Northern Ireland and the first to gate-keep all acute psychiatric admissions. It offers an alternative to in-patient care for patients who in the absence of the service would imminently require hospital admission. HTCR also facilitate early hospital discharge.

The patients will have a serious mental illness or complex psychological needs. They are vulnerable or disabled to the extent that they need intensive or extended hours of treatment and support. Treatment is delivered by a multidisciplinary team offering home-based care from 9am – 9pm, 7 days a week, 365 days a year. The same team also provides a Crisis Response service for people with a mental health crisis outside of working hours. The team triage referrals and gate-keep all potential hospital admissions, seeing patients within 2 hours when a clinical and risk assessment is completed.

If admitted to Home Treatment a comprehensive package of care is offered that on average lasts two to three weeks but can extend up to twelve weeks and may involve several visits per day. Patients and carers are actively involved, with support and education comprising a significant part of the treatment delivered.

Being within the home enables robust assessment of the patient's social supports allowing the team to address directly any effects these may be having. Cases are discussed at twice daily handovers, with review of the overall care plan occurring during the twice weekly, consultant led multidisciplinary clinical meeting. Discharge planning is paramount with discussion on relapse indicators, relapse plans and a joint home visit to handover to a patient's long term key worker.

The switch of the hospital admission gate-keeping role from sector consultants and GPs to the team has been a challenging transition. However, ongoing development of gate-keeping is vital to ensure the continued effectiveness of the team⁴.

We are fortunate that Home Treatment offers an alternative to patients, carers and clinicians. While endorsing it in its own right it is clear that its ultimate usefulness is within the context of an integrated comprehensive mental health care system.

ACKNOWLEDGEMENTS

Many thanks to Dr Neta Chada and Mr Adrian Corrigan from the Home Treatment Crisis Response Team, Southern Health and Care Trust for their advice and support.

The author has no conflict of interest

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PERFORATION INTO THE PERICARDIAL SAC OF AN INFANT: A RARE COMPLICATION OF CENTRAL VENOUS CATHETER INSERTION

Editor,

Cardiac tamponade following insertion of a central venous

(CV) catheter is a rare but recognised complication associated with a high mortality rate, that was addressed recently in a circular from the Department of Health, Social Services and Public Safety in Northern Ireland (1). We report a case of CV line perforation into the pericardium that was diagnosed early by a simple contrast study.



Fig 1. "Linogram" study. Water-soluble contrast has been injected into the left subclavian line. The contrast extravasates from the line tip outlining the central great vessels and the superior aspect of the pericardial sac.

A male neonate was born by elective Caesarean section following an antenatal diagnosis of exomphalos major. During a stormy in-patient course, a left-sided subclavian line (SCL) was inserted on day 33 of life. In the hours that followed, the patient's left arm and face were noted to be "puffy". The SCL was documented to be flushing easily but not bleeding back; its use was discontinued and a "linogram" contrast study requested [Fig. 1]. Contrast was seen outlining the central great vessels and the superior aspect of the pericardial sac. A follow-up chest radiograph showed layering of contrast within the pericardial sac, outlining the heart [Fig. 2]. An echocardiogram demonstrated a small pericardial effusion.

The infant gradually recovered from his surgeries over the next weeks and was discharged at 3 months.

DISCUSSION

Complication rates for CV catheter insertion vary between studies depending upon the puncture site. Earlier studies reported rates of up to 6% for infra-clavicular subclavian line insertion (2), with the rate of complication being less for those operators with greater experience (3,4).

In the described case, no problems at the time of line insertion were recorded in the patient's operative notes, and an immediate chest radiograph showed a catheter that appeared to be well placed. A subsequent contrast study showed the line tip to have perforated into the pericardial sac; a complication that is associated with a significant mortality

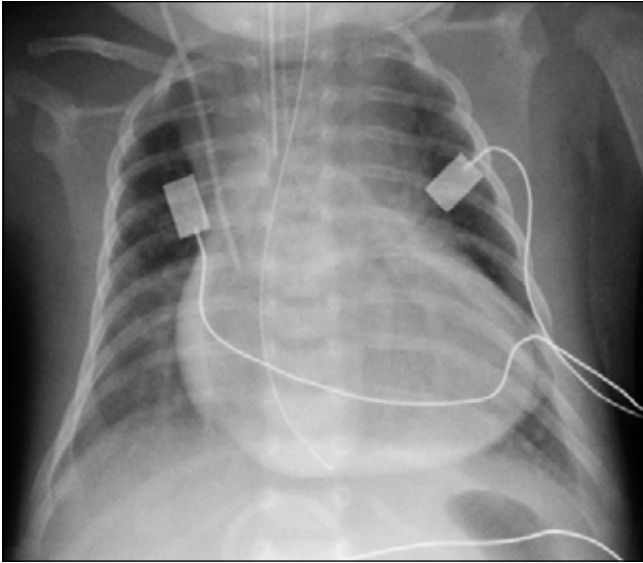


Fig 2. Follow up chest radiograph after removal of the left subclavian line and insertion of a new right-sided internal jugular vein catheter. Contrast is seen filling the pericardial sac, outlining the heart.

rate due to the risks of cardiac tamponade if the problem is not recognised and fluid infusions via the line continue (5). In 2009, a circular from the Department of Health in Northern Ireland highlighted the risks of CV line insertion. It followed a review after a patient died from cardiac tamponade due to a perforated right atrium, as a complication of CV line insertion. Whilst late perforation may be caused by the catheter tip eroding through the vein or chamber wall (2), early tamponade was thought more likely due to the dilator used to assist line placement. The Department counselled

that dilators should not be inserted to the hilt over the guide wire, but should only be inserted far enough to open the vein puncture site. Moreover, cardiac tamponade should be considered if a patient clinically deteriorates soon after CV catheter placement. In the infant described, the line had been in situ for only a few hours before problems became apparent, and its use was immediately halted. This case highlights a rare and serious complication of CV line insertion that both radiologists and intensivists should be aware of.

The authors have no conflict of interest.

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