Ulster Med J 2017;**86(3):**201-206

Letters

PARAMILITARY SHOOTINGS AND ASSAULTS

Editor,

Few doctors working in Northern Ireland will be surprised by the findings of McGarry K et al[1] that 20 years after the IRA and UVF/ UDA 'ceasefires' in 1994 there were MORE patients admitted to the RVH after paramilitary shootings and beatings than before the 'ceasefires'.

The accompanying paper by Napier et al[2] noted that since the 'ceasefires' across Northern Ireland there have been 3691 patients requiring orthopaedic expertise after loyalist and republican attacks. Truly an Irish ceasefire!

My only criticism of these most valuable papers is in their use of the term 'punishment attacks'. This shameful but all too often used term trivialises, sanitises and in essence colludes with what are unjustified, vicious and occasionally murderous crimes.

Shockingly- but not surprisingly- 500 victims were under 18 years old, with some just 12. This is, of course, child abuse.

I can't conceive of any other society where the victims of child abuse would have their abuse described as 'punishment'!

Orwell[3] said: 'political language makes murder respectable and lies sound truthful'.

Doctors must be careful not to fall for the euphemisms and mistruths of propagandists.

Philip J Mc Garry FRCPsych

Consultant Psychiatrist, Belfast Home Treatment, Fairview 2, Mater Hospital

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AUTHOR'S RESPONSE: PARAMILITARY SHOOTINGS AND ASSAULTS

Editor,

Dr. McGarry makes a valid point that the use of the term, "Punishment," implies fault on the victim's behalf. There was no documented evidence that any of the cases included in our study were involved in criminal behaviour.

It is however important to differentiate these assaults from random acts of violence. Considering the significant financial, social and cultural impact of such attacks on our local communities it is time that critical awareness is raised about their ongoing frequency. Perhaps it is indeed time the euphemism of, "Punishment Attack," is replaced with a dysphemism that better reflects the grim reality of the event.

Dr. Kevin McGarry

Core Surgical Trainee Year One, The Emergency Department, Royal Victoria Hospital, Belfast

INAPPROPRIATE ED ATTENDANCES IN NORTHERN IRELAND: COMMENT FROM RCGP NORTHERN IRELAND.

Editor,

We wish to comment on a letter published in the January 2017 edition of Ulster Medical Journal which discusses inappropriate attendance at emergency departments (ED) in two ED departments in Belfast Trust which were largely self-referrals [1].

We feel this retrospective observational survey had many methodical flaws. The most obvious of these was the author's definition of an inappropriate attendance at an emergency department.

This subject has been researched extensively and an internationally recognised definition of appropriate attendance at ED has not yet been made. It is unsurprising then that the range of values of inappropriate attendance in different studies varies from 6% to 80% [2].

The authors define "inappropriate attendance" by "no change in patient management, addition to the patient care or …add to the patient journey." They were however all triaged by a clinician who accepted responsibility for this. Thus, we feel this definition of inappropriateness is subjective and does not take into account the fact that the investigators were relying solely on the accuracy of the information provided on the ED notes and patient's history.

We share the author's frustration at patients accessing services inappropriately however we feel the need to work together to ensure the best care for our patients. We were surprised that 16 cases referred by GPs were deemed inappropriate.

A robust, prospective study on factors influencing ED attendance would be welcome as it could help identify the real issues of attendance – such as social, environmental and professional – and inform future investment in the best solutions.

We feel recent proposals by NHS England of placing a GP in every ED department would be counterproductive. It would destabilise our workforce further and would encourage more patients with primary care problems to attend ED.

Dr Laurence Dorman

RCGPNI Deputy Chair for Policy

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On behalf of RCGPNI Executive Team

Royal College of General Practitioners, Northern Ireland. 4 Cromac Place Belfast. BT7 2JB

Email nicouncil@rcgp.org.uk

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AUTHORS' RESPONSE: INAPPROPRIATE ED ATTENDANCES IN NORTHERN IRELAND: COMMENT FROM RCGP NORTHERN IRELAND.

Editor,

We thank Dr Dorman and the RCGPNI Executive Team for their interest in our work and we are pleased to reply.

Dr Dorman rightly acknowledges that there is no internationally recognised definition of an Emergency Department (ED) inappropriate attendance. A recent survey of ED nurses, doctors and paramedics in three Irish hospitals identified a variety of definitions of inappropriate attendance, with variation within the different professional groups.[1] It is possible that other healthcare practitioners may have disagreed with some of the assessments made by the small group undertaking our analysis of attendances.

We recognise the limitations associated with our review, including its small size and its retrospective nature, which, as we acknowledge in our paper, means that our analysis was limited by the comprehensiveness of the ED notes.

We would welcome further, larger studies into the appropriateness of ED attendances and the characteristics associated with ED attendance. Studies undertaken in other areas have provided some analysis of the determinants of ED use.[2,3]However, despite the limitations which we have noted in our own analysis, we believe that it has given us some useful information on the proportions of attendees to EDs, within one Trust in Northern Ireland, who may have the potential to be seen safely in alternative settings.

Sinéad McGuinness[1], John Maxwell[2], Carolyn Harper[1].

1. Public Health Agency, 12-12 Linenhall Street, Belfast BT2 8BS.

2. Royal Victoria Hospital, Grosvenor Road, Belfast, BT12 6BA.

E-mail: Sinead.McGuinness@hscni.net

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COMPLETE TRANSECTION OF THE RADIAL NERVE ASSOCIATED WITH A CLOSED HUMERAL SHAFT FRACTURE

Editor,

A 29-year-old female sustained a closed, comminuted fracture of her left midshaft humerus (**Figure 1**) with an associated radial nerve palsy, disruption of her right sacro-iliac joint with an associated fracture of the right superior pubic ramus and a stable first cervical vertebral fracture as the result of a high-speed road traffic accident. The pelvic injury was stabilised using two sacro-iliac screws and a halo-vest applied in order to manage her cervical spine fracture. A decision was taken to proceed with operative fixation of her left humeral shaft fracture to assist with postoperative mobilisation.

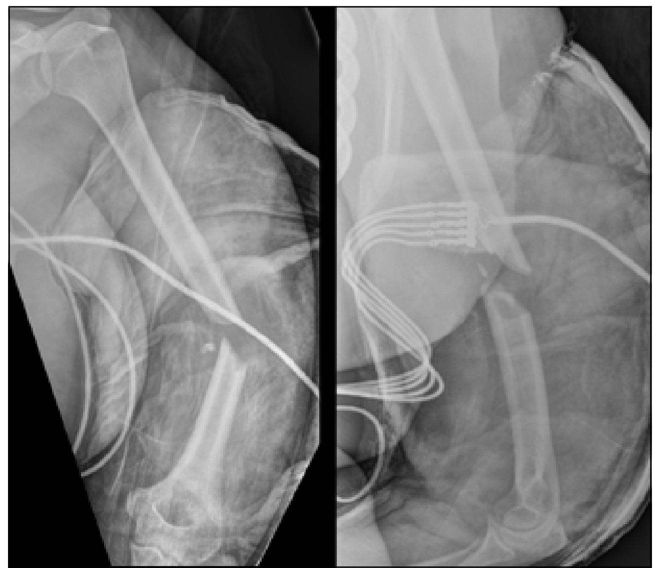

Fig 1. Preoperative anteroposterior and lateral radiographs of left humerus.

The humeral shaft fracture was exposed via an anterolateral approach. The fracture fragments were noted to be widely separated with significant periosteal stripping and soft tissue disruption. The radial nerve was found to be completely transected just proximal to the level of the fracture. The humeral fracture was stabilised using a narrow dynamic compression plate (**Figure 2**). A direct end-to-end nerve repair was performed once fracture stability had been achieved. Postoperatively she was referred for splinting and upper limb rehabilitation. The pelvic and cervical spine injuries healed without complication and the left humeral shaft fracture proceeded satisfactorily to bony union. Approximately 11 months post-injury, the patient regained full recovery of her left radial nerve motor and sensory functions (**Figure 3**).

Approximately 11% of patients with a closed humeral shaft fracture develop a radial nerve palsy with spontaneous recovery of nerve function occurring in approximately 70% of cases and hence the presence of a radial nerve palsy at the time of a closed humeral shaft fracture is not an absolute indication for surgical exploration.[1] Middle third humeral fractures have the highest incidence of nerve injury because

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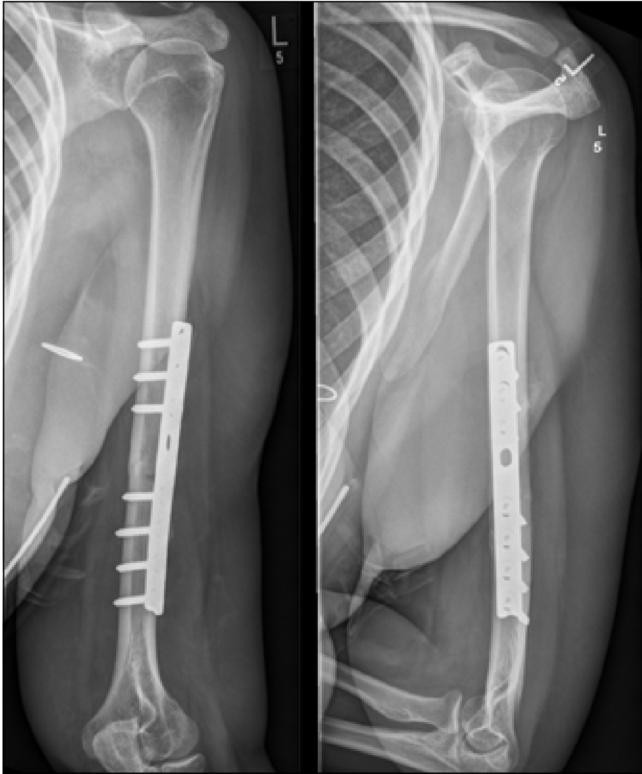

Fig 2. Postoperative anteroposterior and lateral radiographs of left humerus.

the nerve lies immediately adjacent to the periosteum in this region [2]. Closed fractures are more commonly associated with a neurapraxia, whereas neurotemesis is more common in open fractures [3,4].

Leucht et al. [5] reported two cases of radial nerve transection associated with a closed humeral shaft fracture. Both patients underwent operative fixation of their humeral fracture due to their associated injuries and at the time of surgery transection of the radial nerve was noted. The authors concluded that without the additional injuries the two patients would have been candidates for functional bracing with the result that the radial nerve transection would have been missed.

Non-operative treatment of closed humeral shaft fractures usually leads to a satisfactory outcome even in the presence of a radial nerve palsy. However, some patients may have a radial nerve transection which will be missed if their fracture is treated conservatively. We suggest that the possibility of radial nerve transection should be considered in closed humeral shaft fractures with an associated radial nerve palsy which occur as a result of high-energy trauma or those fractures where there is marked displacement of the bone fragments.

Brendan J Gallagher, Paul Hegarty, Shauneen M Kilpatrick, Neville W Thompson

Department of Trauma and Orthopaedics, Altnagelvin Hospital, 700 Glenshane Road, Londonderry, County Londonderry UK, BT47 6SB

Corresponding Author: Mr Neville W Thompson, Consultant Orthopaedic (Hand & Upper Limb) Surgeon.

Email: neville.thompson@westerntrust.hscni.net

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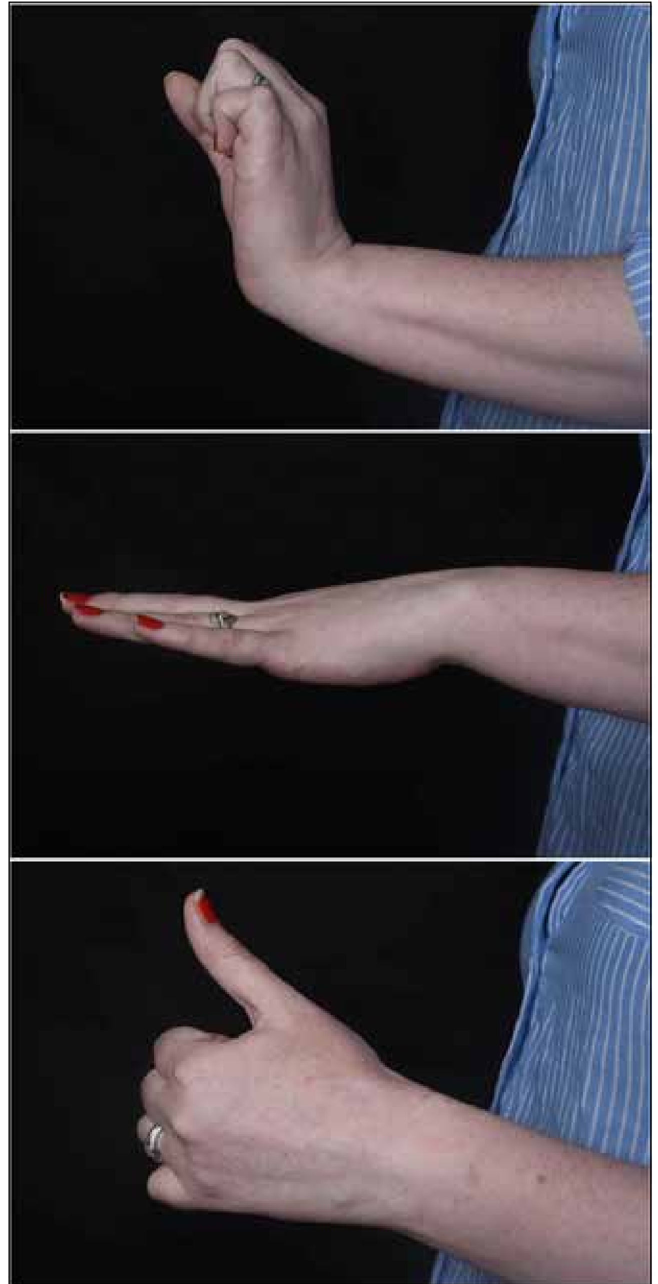

Fig 3. Clinical pictures demonstrating active left wrist extension and active extension of the fingers and thumb left hand.

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BY NC SA

ATYPICAL PRESENTATION OF SOFT TISSUE SARCOMA

Editor,

Soft-tissue sarcomas are rare malignancies of mesodermal origin and constitute <1% of new malignancies. There are multiple histological sub-types and only about 10% of all sarcomas are synovial. They usually present as a painless limb mass. Metastases can be as common as 40% with high-grade tumours and occur most commonly in the lung, but may also affect liver, brain and bone [1].

A 27 year old man presenting with left sided chest pain was found to have multiple soft tissue lung lesions on chest x-ray (Figure1). A CT guided biopsy was unsuccessful and referral for VATS (video assisted thoracoscopic surgery) was made to obtain tissue samples.

Fig 1 Chest X-ray showing multiple lung nodules

At review 1 month after the initial chest X-ray, the presence of long-standing inflammation of the right foot became evident. The right foot had been inflamed for 6 months and was significantly larger than the left with mild erythema (Figure2). MRI of the foot revealed a large lesion at the medial aspect with bony erosion consistent with a malignant tumour.

VATS identified large abnormal lung nodules (Figure3) confirmed to be malignant on frozen section. The histology was not typical of lung carcinoma, melanoma or common pleural/lung lesions. Immunohistochemistry showed positive staining of biphasic spindle cells with CD99, EMA and bcl-2, as well as focal staining with Cam 5.2 and AE1/3 in the epithelioid areas. This favoured a diagnosis of synovial sarcoma confirmed with the presence of t(X;18) translocation identified by molecular studies. No further biopsy of the primary lesion was deemed necessary to confirm the diagnosis of metastatic synovial sarcoma.

The t(X;18) chromosomal translocation identified in the sample sent for molecular pathology is typical for synovial sarcoma and essentially describes a fusion between SSX on chromosome X and SS18 on chromosome 18 [2,3]. This translocation is virtually pathognomonic for human synovial sarcoma [3]. The fusion process is similar to the oncogenesis of certain leukaemias [2].

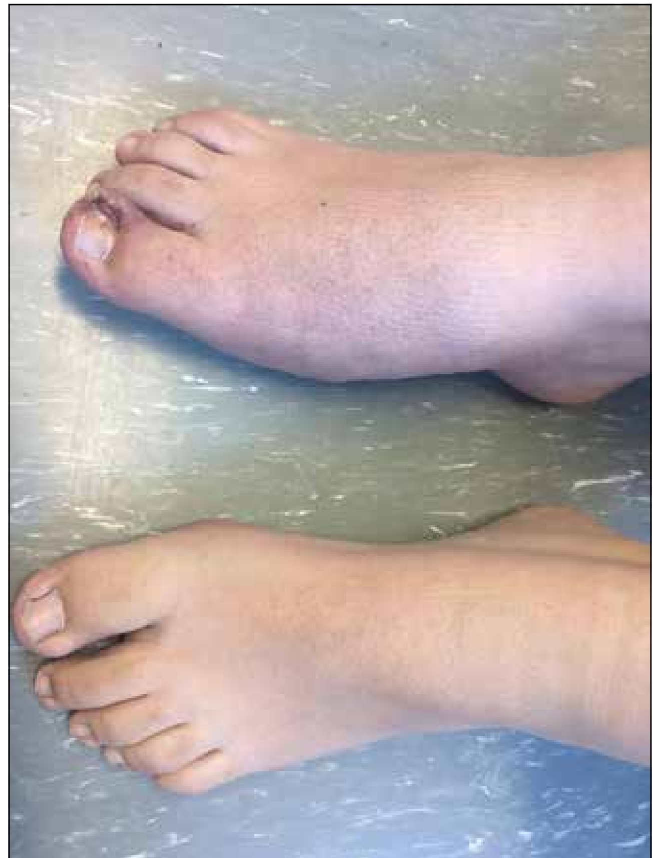

Fig 2 Swollen right foot as compared to left foot, initially thought to be unrelated

The stable SS18-SSX fusion protein created as a result of the translocation is subsequently incorporated into the BAF complex. This prevents the BAF47 subunit, usually part of the complex, from inclusion. BAF47 is a tumour suppressor gene and its absence may play a significant role in the development of synovial sarcoma [2]. Interestingly, proliferation of synovial sarcoma may be potentially reversible if normal complexes are reassembled. This may guide the development of future therapeutic agents [3].

This case highlights the importance of a thorough patient review. This was an atypical presentation of synovial sarcoma with the pulmonary metastases identified prior to the primary

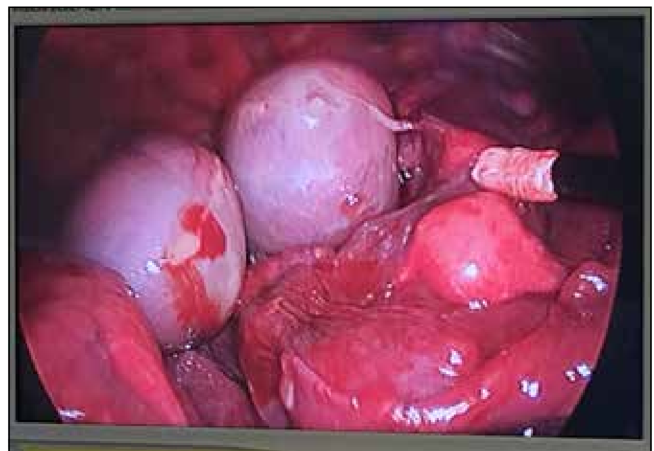

Fig 3 Macroscopic images of lung nodules during VATS procedure

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malignancy. It is unusual for synovial sarcoma to be identified from incidental findings of lung metastases. The patient was treated with trabectadin instead of doxorubicin in view of compromised left ventricular ejection fraction. Trabectadin is at least as efficacious as doxorubicin for the treatment of translocation-related sarcomas [4]. One year after initial diagnosis he is receiving palliative chemotherapy, with metastases mostly stable in size. The mass in the right foot has continued to grow in size, as have some of the pulmonary nodules.

Victoria Rizzo, Harry Parissis

Royal Victoria Hospital, 274 Grosvenor Road, Belfast BT12 6BA.

Corresponding author: victoria.rizzo@belfasttrust.hscni.net

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NO BABY BOOM OR SEX RATIO CHANGES FOLLOWING *FIFTY SHADES OF GREY* IN ENGLAND AND WALES

Editor,

Fifty Shades of Grey (FSOG) was a 7/2011 erotic romance that traces the deepening and complex relationship between a college graduate and a young business magnate, with soft porn elements that include bondage/discipline, dominance/submission, and sadism/masochism. The media hyped this, claiming FSOG "sparked a "mommy porn" revolution".[1] The second and third volumes of FSOG were published in 4/2012. A film adaptation of the first book was released on 13 February 2015.

FSOG was touted as inciting increased coital activity, thereby potentially resulting in a baby boom. "It's one of the hottest and best-selling book series of all time. It has made millions of readers swoon".[1] August authorities were cited as confirming this effect. Robin Milhausen, an Associate Professor of Family Relations and Human Sexuality at the University of Guelph, was quoted: "the material is arousing… Many women respond to the book and don't even know it. It's leading to more sex".[2]

The male to female ratio at birth (male divided by total births: M/T) approximates 0.515 (slight males excess). Numerous factors may affect M/T.[3] Increased coital activity may not only increase the birth rate but also increases M/T as sex ratio at conception follows a U-shaped regression curve on cycle day of insemination. Thus, increased coital activity will increase the likelihood of conception early in the cycle, increasing male conceptions.[4]

This study sought spikes in total births or M/T in England and Wales circa nine months following FSOG books.

METHODS

Monthly male and female births for England and Wales were obtained from the Office for National Statistics for 1/99-8/99 (Ms. Athena Ray – personal communication). The null hypothesis was that FSOG releases in 7/2011 and 4/ 2012 did not influence total births and M/T circa nine months later, i.e. 4/2012 and 1/ 2013.

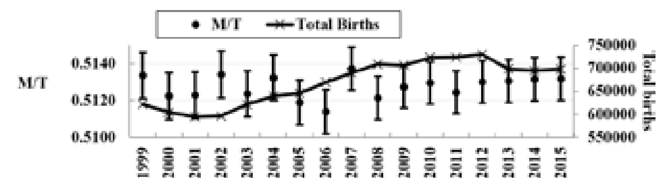

Fig 1. Annual births and M/T for England and Wales, 1999-2015

RESULTS

This study analysed 11831728 live births (M/T 0.5128, 95% CI 0.5125-0.5130). Annual births and M/T shows no discernible spikes (figure 1). A monthly breakdown for 1/2010-8/2016 shows no discernible spikes in total births or M/T at/around 4/2012 and 1/ 2013 (figure 2).

DISCUSSION

Linda Murray, Global Editor-in-Chief of BabyCenter.com stated that "reading '50 Shades of Grey' is acting like an aphrodisiac for women…It's putting them in the mood more frequently and they're having more sex and they're ultimately getting pregnant faster".[1] And the Daily Mail averred that "the meteoric rise of Fifty Shades of Grey is set to spark a new wave of births, according to pregnancy and parenting websites".[5] FSOG was therefore anticipated to result in a "revolution … coming to the delivery room, where a baby boom sparked by the "Fifty Shades of Grey" phenomenon is predicted".[1]

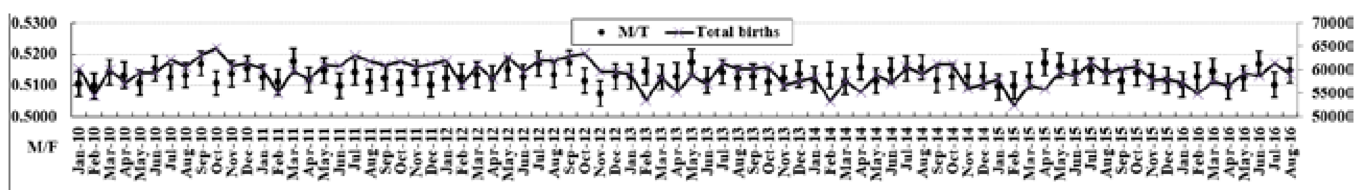

Fig 2. Monthly births and M/T for England and Wales, January 2010-August 2016

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This paper thus highlights the importance of measurement of cause and effect since expected effects may not always ensue from events. It also highlights the importance of the availability of M/T data by month since analyses as carried out in this study are impossible without data at this level of detail.

Victor Grech, Consultant Paediatrician

Academic Department of Paediatrics, Mater Dei Hospital

Correspondence to: Prof. Victor Grech,

email: victor.e.grech@gov.mt

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IS IT TIME TO REVISIT THE RED FLAG REFERRAL SYSTEM?

Editor,

The 'red flag referral' system is currently under stress due to the huge number of suspected cancer referrals. There are guidelines from both the Northern Ireland Cancer Network (NICaN)[1] and the National Institute of Clinical Excellence (NICE)[2] regarding specific criteria for what constituents a red flag referral.

The red flag referral pathway is centred on two groups of patients:

1. 95% of patients identified with cancer should begin their definitive treatment within 62 days of referral (typically General Practice referrals)
2. 'In-hospital' referrals should begin definitive treatment within 31 days of consulting with a specialist and a treatment plan initiated

All upper and lower GI suspected cancer referrals were assessed over a 1-year period (October 2015 – September 2016) in a district general hospital. Both 62- and 31-day referral pathways were analysed. Data were obtained from cancer trackers and checked for accuracy.

For suspected upper GI cancers, there were 2629 referrals over the 1-year period, divided into 1520 62-day referrals and 1109 31-day referrals. There were 164 (6.24%) confirmed cancers. 57 (3.75%) of these cancers were 62-day referrals and 107 (9.64%) cancers were 31-day.

There were 3951 referrals for suspected lower GI cancers over the 1-year period, with 2652 62-day referrals and 1299 31-day referrals. There were 188 (4.76%) confirmed cancers. 63 (2.38%) of these cancers were 62-day referrals and 125 (9.62%) cancers were 31-day.

There was very low progression from suspected to confirmed cancer from red flag referrals for both upper and lower GI symptoms. 62-day referrals for suspected cancer were particularly low (3.75% and 2.38% for upper and lower GI referrals respectively).

In the current environment of increasing demands on the NHS – is it time for current red flag referral criteria to be revisited? We should have a true partnership between secondary care and general practice - setting up a working group between general surgeons, gastroenterologists, and general practitioners to revisit guidelines to determine what is realistic and deliverable in the current financial constrained environment. Perhaps such 'red flag' patients should be referred to community assessment centres for direct access endoscopy. These trained endoscopists may be nurses, associate specialists, or staff grade doctors. It would be especially important for a number of these endoscopists to be sessional family doctors, who are JAG (Joint Advisory Group in Endoscopy) accredited. This would encourage collaboration between general practice and secondary care, allowing for validation and audit of the red flag referral pathway.

Spence RAJ, Mackle E

General Surgical Unit - Craigavon Area Hospital

E-mail: Robert.spence@gmail.com

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