Delirium should be included in guidelines and curriculums

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Sodium reduction is enticing, but what is the full recipe?

Reading the study of the long term effects of dietary sodium reduction on a Friday evening, I wondered whether it could help my hypertensive patients on Monday morning. Unfortunately not: the prescription for sodium reduction is not usable by my fellow general practitioners: “Individual and weekly group counselling sessions were offered initially, with less intensive counselling and support thereafter, specific to sodium reduction.”

How do I translate this vague description for my patients? Those rare clinicians diligent enough to track down reference 2 would find a fuller, but still insufficient, description. It still misses so many details that I (or a dietitian) would need that I don’t know how to replicate it. But there is sufficient detail to show that this form of salt reduction is probably impractical in primary care.

The accompanying editor’s choice suggests, “You might try talking salt in your next consultation,” but that does not seem viable on the basis of either this paper or the previous publications. That is a pity. As a fan of non-drug interventions, I’d like to be able to share them with my patients. But so often the description of what clinicians and patients need to do is so woefully inadequate that it is unusable. If authors are interested in uptake, they need to make interventions practical and provide sufficient details and materials. In the internet world, space limitations are no longer an excuse.

Glasziou (previous letter) pleads for a description of what clinicians and patients need to do. It is not simply about adding salt at the dinner table but about understanding the considerable role that players such as the food industry play in public health. Health protection through national fiscal and legislative policies should have a higher priority than health promotion interventions applied to general, primary care, and workforce populations.

The high risk strategy, the traditional medical approach to prevention, identifies individuals at high risk of subsequent cardiovascular disease events who are then offered behavioural or pharmacological interventions. In contrast, the population strategy seeks to control the determinants of incidence in the population as a whole.

Public health policies need to take into account the role that agriculture, trade, education, the physical environment, town planning, and transport have on cardiovascular disease aetiology. Political action is needed to change urban planning, education, and policies on the agriculture, food, and tobacco industries. Until then, interventions such as salt reduction campaigns and pleading to patients to throw away the salt cellar in afternoon surgery will make little difference to population salt levels.

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1 Blackman T, Statins, saving lives, and shibboleths. BMJ 2007;334:902. (28 April.)

PNEUMONIA FROM VENTILATION

Oral decontamination treats the symptom, not the cause

Oral antiseptics, like semirecumbent positioning and care of the ventilator circuit, merely address the ventilator, and not the cause of ventilator associated pneumonia (VAP). The pivotal step in the pathogenesis of most cases is aspiration of secretions past the...
cuff of the tracheal tube. Aspiration occurs because of a design defect in almost all cuffs currently available, with leakage along folds in the cuff wall.

Manufacturers are now improving the design of tracheal tubes, ensuring maximal cuff performance and incorporating subglottic secretion drainage ports and antibacterial/non-stick linings. Simply preventing aspiration by cuff improvements may have a substantial impact on VAP and reduce the requirement for topical antiseptics or antibiotics.1,4

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DELIRIUM IN OLDER PEOPLE

Approach is now screening, prevention, and recognition

The approach to delirium has shifted from ad hoc treatment to systematic screening and prevention.1 Management may be improved with primary prevention, early detection, and prompt management.

Preoperative cognitive impairment, as measured by the mini mental state examination or the clock drawing test, is an important predictor for postoperative delirium. Most elderly patients developing postoperative delirium after hip surgery have early prodromal symptoms. Low dose prophylactic haloperidol can reduce the incidence.2 Niam et al showed that methods proved to prevent delirium can be useful in routine clinical practice.3

In a large retrospective study only 4% of patients had a recorded diagnosis of delirium, yet an episode may occur in up to 50% of hospitalised older people.1 The poor understanding of delirium by staff stems from a historically low educational emphasis in medical and nursing schools. Increasing doctors’ and nurses’ awareness can be achieved through a brief and inexpensive educational programme, which significantly decreases the prevalence of delirium among older inpatients, increases recognition of cases, and can be easily rolled out across hospital units caring for older people.3

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Delirium should be included in guidelines and curriculums

One critical factor in the underdiagnosis and undertreatment of delirium in the United Kingdom is likely to be its unsatisfactory coverage in core guidelines and curriculums.1 Delirium is not mentioned in the draft guideline on acutely ill patients in hospital from the National Institute for Health and Clinical Excellence (NICE).2 Delirium is also absent from the Joint Committee of Higher Medical Training curriculums for general internal medicine and acute medicine.3,4 “Acute confusional states” are mentioned in the latter, but only in the context of minimising distress. In the curriculum from the Royal Colleges of Physicians the sole reference to delirium is in the section on aggressive/disturbed behaviour,5 although only a few patients with delirium display aggression. “Acute confusion” appears in the top 20 presentations and the section on medicine in the elderly but with no mention of delirium.

Care of patients would be greatly facilitated if delirium were covered adequately in core guidelines and curriculums. Consistent use of the term delirium and not its multiple, ill defined synonyms would reduce the terminology chaos and diagnostic imprecision which partly underpin the poor rates of recognition.6

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DRUG COST INITIATIVE

Link cost to clinical outcome

The laudable UK initiative to drive the costs of drugs down to affordable levels assumes that there is consistency in drug pricing between producer and recipient countries and that price is a barrier to use.1

When generics are included in pricing studies and compared with the price per gram of active ingredient, Japan and Switzerland are more expensive than the United States. When price per standard unit (a rough measure of dose, which differs across countries) is compared, Canada, Germany, Switzerland, and Sweden are more expensive than the US. And many governments subsidise research and development of their pharmaceutical and vaccine industries, making international comparisons difficult.2

Other factors contribute to a drug’s price when it finally reaches a patient. Some governments procure medicines efficiently but charge much higher prices to patients.3

Yet the problem remains more profound than simply a matter of prices: the fragility of health systems. The UK would help the developing world more by disseminating best practices for disease management through the principle of rational choices between therapeutic alternatives which promise the most advantageous economic value relative to clinical outcome.

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