


Authors’ reply

SIR—We were interested to read Dr Jolobe’s experience with 62 patients who had choledocholithiasis. In our article we concentrated on the symptoms with which the patients who had gallstones presented, such as abdominal pain and jaundice, whereas Dr Jolobe uses presentation to describe underlying conditions which can be caused by gallstones, such as septicemia and acute pancreatitis.

Dr Jolobe details one patient who, in the absence of bacteriuria, had an Escherichia coli septicemia on three occasions over 10 years. An abdominal ultrasound assessment showed a gallbladder stone on the first but not on later occasions, while subsequent endoscopic retrograde cholangiopancreatography (ERCP) demonstrated a stone in the common bile duct; no follow-up information was given. It would seem ultrasound failed to detect a stone in the common bile duct. Our paper reported the sensitivities for detecting dilated common bile ducts and stones within the common bile duct to be 86% and 69% respectively.

Dr Jolobe commented that improvement in liver function tests can occur when stones are present in the common bile duct and that this may erroneously suggest a stone has passed spontaneously, whereas it may simply have disimpacted. It may also mean that while a stone principally responsible for the obstruction has passed spontaneously, residual stones remain within the common bile duct. In five of our patients a stone passed spontaneously, leaving a clear common bile duct on each occasion.

We do not believe Dr Jolobe’s experience of undertaking ERCPs successfully in three patients without having a previous abdominal ultrasound assessment is sufficient to validate such a practice. Ultrasound provides valuable information, is cheap and totally non-invasive, and can be undertaken rapidly without causing significant delay in further management options. Magnetic resonance imaging cholangiography carries no risk and is likely in some circumstances to supersede diagnostic ERCP.

Dr Jolobe highlights use of biliary endoprosthesis for gallstones. This was unnecessary in our patients as the common bile duct was cleared of stones in all patients in whom the common bile duct could be cannulated, although eight patients needed mechanical lithotripsy. Endoprosthesis could not have been undertaken in the two patients in whom the common bile duct could not be cannulated.

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Readmission of patients discharged from emergency departments

SIR—Caplan et al. describe an increased risk of readmission of older people after discharge from an emergency department [1]. They identify factors relating to frailty and dependence in activities of daily living which predict readmission. These important results highlight some of the difficulties in elderly patients managed by accident and emergency staff.

We believe that, in addition to problems with functional assessment, older patients pose diagnostic difficulties. In a prospective series of 111 older patients (>65 years) discharged from our accident and emergency department in whom no clear diagnosis had been reached, we found a high rate of readmission. Nine percent were readmitted within the first month and 33% within 6 months. Patients initially presenting with chest pain or dizziness/funny turns were at highest risk [2].

Deficiencies in training of accident and emergency doctors in the care of elderly patients have been recently acknowledged [3]. Involvement of geriatricians in accident and emergency departments has been proposed [4, 5]. As a speciality, we should find ways to improve the care of the increasing numbers of elderly patients presenting to accident and emergency departments. Formal teaching sessions, compulsory training of Senior House Officers in geriatric medicine or active participation in accident and emergency by geriatricians are some ways in which this might be achieved.

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Letters to the Editor


