The predicted risk factors of heavy lifting, prolonged sedentary activity, chronic cough, varicose veins, pregnancy, constipation, and family history of haemorrhoids were significantly more frequent among cases compared with controls ($p < 0.05$, $\chi^2$ or Fisher’s exact tests), with the latter risk factor having the most significance ($p = 0.0005$). Among cases, anal pain, prolapse and rectal bleeding were the most frequent presenting symptoms. Of medical concern was the delay in consultation, exceeding two months in 77 per cent of cases. Among this group, 45 per cent expressed delay of around one year or more, the maximum being 11 years. Illiteracy (no formal education) was the only significant factor associated with long delay ($p = 0.003$).

There is a widespread clinical impression that rapid socioeconomic development and changes in lifestyle have led to the emergence of anorectal disease in the United Arab Emirates. Currently, malignancy ranks third behind cardiovascular disease and accidents as leading causes of mortality, with malignancies of the digestive system being the most frequent, ahead of carcinomas of the bronchus and breast. Clearly, there is scope for a health intervention input to increase awareness and reduce embarrassment among people with symptoms suggestive of anorectal disease, and so reduce delay in consultation. Given the availability of colonoscopy at the present time, it is noteworthy that benign anorectal disease and colorectal neoplasia frequently coexist. There are also cost benefits in addressing the delay factor, as conversion of first-degree to second- or third-degree haemorrhoids, and of acute to chronic fissure, is associated with more specialized surgery and more frequent attendant postoperative complications.

References


A pilot study of the use of clinical guidelines to determine appropriateness of patient placement on intensive and high dependency care units

Sirs,

There are a number of aspects of this paper1 with which we disagree:

1 The results reported are derived from a survey carried out by Dr Donnelly and his colleagues in response to a series of objectives agreed by a Working Party of the Hospital Medical Specialists Sub Committee of South Glamorgan District Medical Committee. This Working Party was chaired by one of us (M.R.), who disagreed with the classifications used for ITU and HDU and was not involved in the preparation of this paper. The interpretation of the data reported is, therefore, that of Dr Donnelly and his colleagues alone.

2 The technique used for assessing the clinical dependence of patients is heavily suspect. This applies particularly to the use of telephone calls to obtain such data. Also, the table is confused by obscure abbreviations and terminology which does little credit to the referees.

3 Locally developed guidelines in relation to a subject of national importance are inappropriate. Failure to adopt definitions of ‘intensive care’ and ‘high dependency care’ already produced by the Association of Anaesthetists should be explained.2,3

4 The designation ‘High Dependency Unit’ can only be justified by appropriate levels of staffing and equipment, which are not stated for the Units described.

5 The satisfactory rates of ITU bed usage reported in this study almost certainly reflect the fact that in Cardiff there are High Dependency Units. However, as stated in the paper, only 15 per cent of hospitals have HDUs.4 This almost certainly explains our findings in a national study,5 which showed that as many as 48 per cent of patients in ITUs could be adequately cared for in HDUs. This is obviously of vital current importance in connection with the desperate national shortage of ITU beds.

6 In our view, the paper does not sufficiently acknowledge that an intermediate level of clinical care is necessary in acute hospitals, and there must now be very few clinicians who would disagree. It is not disputed that acceptable guidelines for the use of ITUs and HDUs should be
adopted, if only for reasons of effective resource utilization. What is not acceptable is that only 15 per cent of UK hospitals should provide an intermediate level of acute clinical care in 1996.

Reference


Reply

Need for guidelines not disputed

Sirs,

The technique for this study was presented to the Working Party at its third meeting and agreed, subject to some further work on the criteria which was subsequently done. This included the plan to telephone every acute ward, except paediatrics, in the three study hospitals to identify ward patients who might have been considered better suited to an HDU or ITU bed. This was the only practical way of screening over 1300 acute beds on a daily basis, and where there was the slightest doubt expressed by the ward staff one of the researchers (D.O’B.) visited the ward and formally assessed the patient. The study proposal was also presented to the relevant clinical directors within all three hospitals and approved.

With regard to the other comments, we did in fact make reference to the two important reports of the Association of Anaesthetists of Great Britain and Ireland. If more effective use of HDU beds is to be encouraged in response to the concern over intensive care provision then clinicians and managers need to know how they are currently used. The purpose of reporting this study was to encourage a debate about the utilization of HDU beds in particular, and we note that the adoption of guidelines for their use is not disputed.

Announcement

The Royal College of Pathologists
One Day Symposium: Diet and Cancer

This symposium will take place on Thursday 13 March 1997.

For further information please contact:

The Royal College of Pathologists
2 Carlton House Terrace
London SW1 5AF
UK