how to proceed should adverse events occur, in the knowledge that any that do occur are likely to be little more than minor.

The subjects in our study represented the spectrum of heart failure patients in the community, and included a greater proportion of women (25%) and elderly people (mean age 67, range 19–91) than participated in randomized trials.1,2 Our group also included patients who would have been excluded from these trials on account of electrocardiographic conduction abnormalities (present in about one third of our population), demonstrating the safety of this approach even in this subgroup. Patients with grade IV heart failure were under-represented in our population but with one adverse event in five cases, it seems reasonable to continue to initiate beta-blockers in such patients in hospital.

Compliance with guidelines on heart failure management is poor, with 5% of eligible patients receiving beta-blockers in the UK.3,4 The obstacle of initiating beta-blockers under medical supervision may be limiting the uptake of this effective treatment. Recommending home initiation for most patients with mild-to-moderate symptoms should increase opportunities for general practices to develop local heart failure services and facilitate the implementation of national guidelines.

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D.S. Wald
R.S. More
M. Martin
Department of Cardiology
St. Mary’s Hospital
Portsmouth

L. Hughes
C.J. Reid
Department of Cardiology
St. Richards Hospital
Chichester

References

The right patient in the right place at the right time

Sir,

We compliment Dr Goldhill on exploring and exposing problems of selection for intensive care.1 His observations are worth more than a dozen statistical analyses or reports and are supported by our own experience and research from 1962. General intensive care is an important branch of high technology medicine, the aim of which must be that its benefits exceed its burdens.2 Put simply, this means ensuring the right patient is in the right place at the right time.3 In the UK, general intensive care started in 19594 and yet this goal still remains elusive. Intensive care can benefit patients with very varied diagnoses, but does the lack of the necessary comprehensive knowledge and experience explain the too-many errors? For some diseases, such as severe acute asthma, we have shown that simple observations made quickly will suffice5 and the results can then be near perfect.6 In contrast, assessing closed trauma to the abdomen can be difficult. The detection of patients who should benefit from intensive care can be helped by routine screening of simple bedside observations. An example, the Modified Early Warning Score (MEWS), was recently published by Subbe et al.6

For three decades, decision-making by hospital nurses and doctors has been influenced by published policies (guidelines, protocols). Such policies were used at our hospital from 1962 to 1983, and encompassed intensive care, drug prescribing and resuscitation.7 It was soon appreciated that such policies were doomed to failure unless they were enforced; the policies then became rules. The anticipated cry of infringement of clinical freedom was countered by Professor Hampton’s edict ‘clinical freedom is dead and should have been buried years ago’.8

The 40 years of failing to get the right patient in the right bed at the right time pales into insignificance against the 140 years of lack of progress in patient nutrition. In 1859, Florence Nightingale stated ‘every careful observer of the sick will agree in this, that thousands of patients are annually starved in the midst of plenty’.9 Although nutrition
of in-patients is easily achieved, it is not widely applied. Recently, Kelly et al. have repeated this message: ‘since there are serious consequences (to malnutrition), and effective simple treatment is readily available, increased awareness is required, with routine assessment of nutritional status in all patients’. Similarly, patients or relatives have no problem in deciding whether part of a hospital is dirty. What an indictment of existing staff that outsiders are needed to show them the truth. It appears that criteria for admission to intensive care should join these other topics awaiting solution. A simplistic answer could be more training and yet more training, but the underlying problem would remain: getting hospital staff to use basic medical knowledge allied to simple patient observation. If we don’t achieve this, Florence Nightingale’s words may continue to ring true into the next century.

I.J. Gordon
E. Sherwood Jones
Prescot
Merseyside

References

Weight gain and treatment for thyrotoxicosis

SIR,

We would like to highlight an important and often neglected area in the treatment and management of thyrotoxicosis. It has been the observation of the authors that following treatment for thyrotoxicosis, and rendering patients euthyroid, weight gain and hence compliance with treatment can be problematic. To determine whether treatment for thyrotoxicosis is associated with excessive weight gain we performed a retrospective case report analysis.

We studied 65 patients who had completed treatment for thyrotoxicosis. Weights at presentation of the untreated disorder, and weights at treated euthyroid and 6 months post restoration of the euthyroid state were ascertained from the case notes. Weight and height prior to the onset of hyperthyroidism were ascertained by direct questioning of all patients. Mean weight changes from both premorbid and hyperthyroid states were compared with weights when the euthyroid state was restored and 6 months after (Table 1). Patients were divided into two groups determined by their premorbid Body Mass Index (BMI): 46 patients in the normal weight group (BMI 19–25), and 19 in the overweight/obese group (BMI > 26). Weight change was also compared according to the method of treatment (carbimazole alone vs. radioiodine vs. surgery).

Weight invariably increased with treatment, and continued to do so 6 months after restoration of the euthyroid state. The mean weight gain from hyperthyroid to 6 months post-treated euthyroid state was 7.2 kg (range –3 to 23.8 kg). Mean weight loss from premorbid to hyperthyroid states was 2.37 kg (range –4 to 13 kg). Thus overall mean weight gain from the premorbid state to 6 months post restoration of the euthyroid state was 5.34 kg (range –3 to 23.8 kg). Weight gain was greatest for those who were initially overweight/obese (mean 7.53 kg, range –3 to 23.8 kg) compared with the normal group (mean 4.38 kg, range 0.1 to 19.6 kg). Although there was an obvious increase in weight in both groups, analysis did not reveal a statistical difference between the two. Equally, there was no statistical difference between treatment modalities. Twenty-seven patients developed hypothyroidism after treatment (24 females, 3 males, 20 post-radioiodine and 7 post-surgery) and required thyroxine therapy to maintain a euthyroid state. There was no statistical difference in weight gain between those who required thyroxine (mean 5.67 kg, range –3 to 19.7 kg) and those who did not (mean 5.23 kg, range –1.3 to 15.5 kg).