I would like to draw your attention to some of the varied content within this month’s issue of QJM.

The review article by Noble and colleagues provides a helpful overview of what is a complex topic that is nevertheless the focus of much current research and attention. The term “glycocalyx” (literally “sugary coat”) has many interpretations within the biomedical literature. In this context however it refers to the outer component of vascular cells. The glycocalyx is thought to provide protection against atherosclerotic disease. The mechanisms whereby it achieves this is discussed in detail. The multifaceted relationships between the glycocalyx, nitric oxide, hyperglycaemia and other risk factors are explored. The authors argue that dysfunction of the glycocalyx in arteries (for whatever cause) may be the first step in the atherothrombotic process. This may be a simplistic model and may provoke discussion.

Of the original research papers this month, several focus on evaluation of the outcomes of several clinical services. For example, there is another paper that assesses the impact of a medical admission unit (MAU) on clinical care. St Noble et al. describe the establishment of a MAU. This required substantial changes in consultant and junior doctor working patterns. A unique feature of this new service was that there was an attempt to maintain continuity of care by the medical team—a highly challenging enterprise considering the implications of the European Working Time Directive on junior doctor rotas and the institution of shift working. A frequently heard complaint by doctors in training is that the opportunities for continuity in training are disrupted by shift working and associated time off duty. In other words, it is now more difficult for trainees to follow patients through their journey from admission to discharge. The new working patterns included the concept of having a consultant of the weekend with aligned junior medical cover. The authors reported improvements in several outcome measures: improved direct discharge rates and patient length of stay with no significant increase in readmission rates. While these findings are encouraging, some degree of caution is needed with respect to their interpretation; for example the authors acknowledge that this study was not designed to examine mortality rates. Further studies using this model of service delivery would be welcome.

Many readers will be familiar with the concept of the integrated care pathway i.e. ICP (also known as a care protocol or a critical care pathway). Many examples of this initiative are evident in practice; however the attributes of a good ICP would include an evidence base for its development, local relevance and a multidisciplinary focus. The paper by Jones describes the development, implementation and evaluation of an ICP for the management of primary biliary cirrhosis, a chronic and distressing condition. This particular ICP is noteworthy for the fact that in addition to providing guidance for the management of liver disease, it also acknowledges the impact of associated symptoms and complications that have a significant impact on patient well-being. These include chronic fatigue, osteoporosis and severe itch. The new ICP was applied to 225 patients and was subsequently appraised. High levels of patient satisfaction were reported with perceived improvement in overall quality of life.

How should aortic stenosis (AS) in the elderly patient be managed? According to some sources the prevalence of AS in those aged 80 years and older may be as high as 20% and the condition, if untreated, has a relatively high mortality and morbidity. Aortic valve replacement (AVR) is a treatment of choice for fit elderly patients and this procedure now has acceptable outcomes. The paper by Kojodjojo et al. compares outcomes for patients with AS divided into three groups: those who received surgery, those who were fit for surgery but refused it and those who were treated...
conservatively because they were not considered to be fit enough for surgical intervention. They found that fit patients with AS who refused surgery had a 12-fold increased risk of mortality. The authors acknowledge that their study has some limitations but there are clear implications for informed decision-making with fit, elderly AS patients. A paper from Belgium should also be of interest to those who care for elderly patients. The hypothesis is that there may be an association between two commonly encountered phenomena in this age group: mild asymptomatic hyponatraemia and fractures due to falls. Low serum sodium (<135 mEq/l) is frequently observed in older patients. Hyponatraemia may have a multifactorial aetiology and when severe, has been shown to be associated with both general and focal neurological signs. Falls and their associated injuries in the older patient are also relatively common and result in a significant health care burden. In this case control study of over 500 patients, hyponatraemia was found to occur more often in patients who had sustained a fracture due to a fall. It is suggested that hyponatraemia causes gait and balance disorders in the elderly and this results in an increased tendency to falls. A degree of caution is obviously needed with respect to the interpretation of these findings; however, the authors of the study have shown that mild asymptomatic hyponatraemia is at least a risk factor for falls in the elderly patient. The presence of hyponatraemia in older patients should therefore be monitored and managed appropriately.

Finally, I would like to draw your attention to an advert placed elsewhere in this month’s edition. QJM would welcome non-clinical reflective pieces from readers on a variety of subjects in order to replace the CODA series previously written by John Launer. What we are looking for are articles of about 1000–1500 words that describe personal views, historical perspectives, memorable patients or inspirational clinicians etc. In fact the only requirement would be that the piece is vaguely related to health care and is well written. QJM would of course pay for all published material. If you want to consider writing for QJM or have potential pieces to submit contact me on mjbannon@btinternet.com. I look forward to hearing from you.

Michael Bannon
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