As editor I have noted the relatively large number of submitted papers that do not properly belong to the category of “primary research” but which might be more appropriately classified as representing descriptions of clinical audits. In general, these papers describe a situation where there is an agreed method of treatment for a disease or disorder and the authors evaluate adherence by clinical teams to established protocols. The paper by Cunnington et al is a case in point. They describe a prospective audit which looked at compliance with indications for pacing in 95 patients. It was found that although a significant proportion of patients studied had a clear indication for permanent pacing, this often was overlooked for various reasons. This finding was of more than academic interest. Of those patients whose indication for pacing was missed, nearly 80% experienced adverse events of varying severity. So, should QJM publish what are in effect audit papers in addition to primary research? I would be interested in hearing your views on this as many journals reject audit papers as part of editorial policy. It could be argued that QJM does have a useful role here in alerting clinicians to the fact that definition of evidence based protocols alone does not necessarily guarantee high standards of patient care. After all, what is the point of primary research if the findings are not successfully implemented in practice? One wonders for the reasons for this failure of implementation: is it educational, lack of resources or systematic?

This month’s issue includes (unusually for QJM) a paper from primary care. The topic however is of considerable relevance to secondary care physicians, especially those who provide care for older patients. Gribbin and colleagues from Nottingham have attempted to quantify the incidence and subsequent mortality resulting from falls in the elderly. Primary care represents an ideal setting in some respects for epidemiological studies. QJM has published a dozen or so primary research papers on the broad topic of falls in the elderly and this study is a useful addition. It was found that following a cohort study of patients aged 60 years and over that the crude incidence rate of recorded falls was nearly 4 per 100 person years in a primary care setting. The rate of recurrent falls was 0.67 per 100 person years. Extrapolating this data to a wider context, it was estimated that nearly half a million falls in the elderly are recorded within primary care each year in the UK. Falls are more likely to occur in women, older patients and those who were socially disadvantaged. There was a significant subsequent risk for mortality in those patients who had experienced a fall. This represents a huge burden on health care resources: surely a topic for health care promotion and one for joint action (and further research) between primary and secondary care?

The management of unexplained syncope continues to represent a challenge. In several large studies the underlying cause remained elusive in between 60–75% of cases. Standard work-up for unexplained syncope, in addition to history taking and examination, includes electrocardiogram, head-up tilt test and carotid sinus massage. There is some evidence that a standardized and stepwise approach is more likely to elucidate an underlying diagnosis in up to 75% of cases. Parry and colleagues from Newcastle describe the potential use of another diagnostic tool. Adenosine has been implicated in the pathogenesis of syncope which has a vaso-vagal origin; hence intravenous administration of adenosine has been used in the diagnosis of syncope where there is a suspicion of such bradycardia-pacing indications as sinus node dysfunction, atrio-ventricular block and cardioinhibitory carotid sinus syndrome. This pilot study suggests that adenosine testing reliably identified patients with definitive bradycardia-pacing indications.

This month’s helpful review by Currie deals with relatively new diagnostic techniques for lung cancer. While the five year survival rate for this
common cancer are disappointing, early diagnosis with correct staging may improve the outlook considerably. The review considers the indications and effectiveness of positron emission tomography/computed tomography (PET/CT), transbronchial needle aspiration (TBNA), endobronchial ultrasound (EBUS), oesophageal ultrasound and medical thoracoscopy. Undoubtedly PET/CT is a useful tool for the detection of both local and distant metastasis. However, tissue confirmation of lymph node involvement is also required for accurate staging purposes. Ultrasound guided transbronchial and transoesophageal biopsy both enable a less invasive method for mediastinal staging. Experience with these diagnostic techniques is encouraging and may become standard, hopefully improving the prognosis for patients with lung cancer.

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