END-OF-LIFE COMMUNICATIONS

We read with great interest the editorial article titled ‘End-of-life communication: let’s talk about death.’ The editorial emphasises the advantages of, and addresses some of the barriers to, end-of-life discussion. In Eastern culture a significant number of patients’ relatives will act as bearers of bad news and feel strongly that patients should not be informed of this news. There is uncertainty over how the news is then communicated between the family members and the patient. Physicians in these cultures may be forced to follow family wishes. These ‘do not tell’ demands are major barriers to end-of-life discussion in Eastern countries.

We conducted a survey in a questionnaire format to obtain cancer patients’ (cohort I; n=100) and their relatives’ (cohort II; n=103) perspectives regarding communication of cancer-related possible bad news throughout the cancer journey. One of the questions was ‘Should the patient be involved in end-of-life discussion?’ 56% of patients answered ‘yes’ while only 30% of relatives answered the same (Chi-square, p<0.001). This response shows that (a) more than half of cancer patients in Saudi Arabia want to be involved in end-of-life discussions and (b) a majority of relatives (70%) were against discussing end-of-life issues with patients.

According to these findings, relevant healthcare professionals (HCPs) should strive to identify those patients who want to have this discussion by asking how much information the patient wants. Agreeing to relatives’ ‘do not tell’ demand (70% of responders) would deprive 56% of patients who otherwise want this discussion.

From our experience, relatives are anxious that disclosure of bad news and end-of-life discussions may deprive patients of hope. One way to change this perception is for the HCPs to explain to the relatives over how the news is then communicated between the patient and the family. Physicians in these cultures may be forced to follow family wishes. These ‘do not tell’ demands are major barriers to end-of-life discussion in Eastern countries.

If a holistic approach is acknowledged to be the goal for clinicians, are Cartesian divisions of this nature best viewed with caution?

P Myerscough

MANAGEMENT OF HYPERKALAEMIA

We read with interest the recent comprehensive review article on the management of hyperkalaemia by Maxwell et al. in the Journal (J R Coll Physicians 2013; 43:246–51). Furthermore we commend the authors on raising the profile of this important clinical matter within the Health Service over recent years. We do however wish to highlight an important, and often underdiagnosed, cause of hyperkalaemia from our own area of practice – that of pseudohyperkalaemia due to thrombocytopenia.

Potassium is released from platelets during clot formation. Most biochemistry laboratories use clotted blood samples (i.e. patient serum) when measuring potassium levels. Therefore, if the circulating platelet count is high, this may lead to spurious hyperkalaemia on laboratory testing. As Maxwell et al. allude to in their review article, the use of lithium heparin specimen tubes (i.e. anticoagulated blood) will provide a much more accurate analysis of the true potassium level in patient plasma.

By way of illustration, we were recently involved in the care of an 81-year-old patient admitted with recurrent...
hyperkalaemia. Background medical history included hypertension and chronic renal impairment. Potassium was 6.4 mmol/L on admission. No electrocardiogram (ECG) changes were present. Three recent biochemistry samples taken in primary care over the preceding month all showed potassium levels between 6.0 and 6.5 mmol/L. Review of his other laboratory tests identified a thrombocythaemia (platelet count 695 x 10^9/L) that had been slowing rising from normal levels 18 months previously. Subsequent investigations, including JAK2 V617F analysis, confirmed a diagnosis of the myeloproliferative neoplasm essential thrombocythaemia.

Given the potential morbidity associated with the treatment of elevated potassium levels we would remind readers of the need to be vigilant to the possibility of pseudohyperkalaemia and to perform biochemical analysis in such a situation with lithium heparin anticoagulated blood whenever possible.

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Reference

1 Ong YL, Deore R, El-Agnaf M. Pseudohyperkalaemia is a common finding in myeloproliferative disorders that may lead to inappropriate management of patients. Int J Lab Haematol 2010; 32: e151–7. http://dx.doi.org/10.1111/j.1751-553X.2008.01114.x

INVITATION TO SUBMIT PAPERS

We would like to extend an invitation to all readers of The Journal of the Royal College of Physicians of Edinburgh to contribute original material, especially to the clinical section. The JRCPE is a peer-reviewed journal with a circulation of 8,000. It is also available open access online. Its aim is to publish a range of clinical, educational and historical material of cross-specialty interest to the College’s international membership.

The JRCPE is currently indexed in Medline, Embase, Google Scholar and the Directory of Open Access Journals. The editorial team is keen to continue to improve both the quality of content and its relevance to clinical practice for Fellows and Members. All papers are subject to peer review and our turnaround time for a decision averages only eight weeks.

We would be pleased to consider submissions based on original clinical research, including pilot studies. The JRCPE is a particularly good forum for research performed by junior doctors under consultant supervision. We would also consider clinical audits where the ‘loop has been closed’ and a demonstrable clinical benefit has resulted.

For further information about submissions, please visit: http://www.rcpe.ac.uk/journal/contributers.php or e-mail editorial@rcpe.ac.uk. Thank you for your interest in the College’s journal.

The editorial team,
The Journal of the Royal College of Physicians of Edinburgh