Letters to the editor

Have we improved in diagnosing hip fractures?

Hip fractures should be promptly diagnosed to improve outcomes. Even though X-rays have a sensitivity of over 90%, up to 15% of fractures are undisplaced and may be difficult to identify. Occult fractures occur in 1–3% of patients and in the absence of shortening or rotation of the affected limb, they could be overlooked easily on clinical assessment.[1,2] Since there are clear algorithms for patients with suspected hip fractures,[3] we assessed our current detection rate through this retrospective study.

We identified all patients with hips fractures over a 12-month period. We analysed the electronic imaging system and clinical records to identify how many had further investigations to confirm a fracture following an initial hip X-ray and also how many had hip X-rays in the preceding four weeks for a suspected hip fracture.

Three hundred and forty-two patients had a fractured neck of femur. There were four males and 16 females and the mean age was 80. In 20 patients, hip fracture wasn't apparent on the initial X-ray. In 11 out of 20 patients there was either clinical or radiological suspicion of a fracture which was confirmed on further cross-section imaging.

In the remaining nine patients, the assessing clinician was satisfied that there was no fracture based on the negative X-ray. They were either discharged home or referred to the general internal medicine department (GIM) for further management. In four patients, persistent pain and change in clinical findings prompted further imaging and the other five had a subsequent fall due to pain or a leg giving way that led to further imaging which confirmed a fracture. In all these patients, fractures were identified at the same site where it was originally suspected. In this group, the duration between the initial presentation and confirmation of a fracture was three weeks (range 2–4 weeks). There were no post-operative deaths.

In around 6% of patients in our study, the initial X-rays did not confirm a fracture. 3% had further cross-sectional imaging during the index admission which confirmed a fracture. However in around 3% of patients, the assessing clinicians were satisfied with the apparently normal X-ray and took no further action and a fracture was only identified after a few weeks. Even though half of this group had a further fall, it would be difficult to establish whether the fall caused the fracture or the fall displaced an occult fracture.

Despite guidelines and increased awareness, we are still missing hip fractures in around 3% of patients. It is likely these patients might have had an occult fracture without any displacement and subsequent actions like passive movement or walking resulted in displacement at which point the fracture was easily identifiable.

Our study shows that we still haven't improved in diagnosing hip fractures on initial admission. Since patients without obvious fractures are often referred to GIM for pain control and rehabilitation, clinicians should be vigilant and have a low threshold to pursue further imaging if a fracture is suspected.

Amit Goel
Specialty Doctor, Department of Orthopaedics; Glan Clwyd Hospital Rhyl, UK
Vedamurthy Adhiyaman, Indrajit Chattopadhyay
Consultant Geriatricians, Department of Care of the Elderly; Glan Clwyd Hospital Rhyl, UK
Email: Vedamurthy.adhiyaman@wales.nhs.uk
doi: 10.4997/JRCPE.2020.229

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Ictal asystole – a letter within a letter

As authors, we welcome correspondence from patients who read our published articles. Following on from the recent publication of our article reporting two cases of ictal asystole and the related diagnostic and management conundrums,[1] we were privileged to receive a letter from another patient suffering from this condition. Given the rarity of ictal asystole and a lack of patient advocate groups, we thought it would be important, with permission, to share the contents of this letter to continue to raise awareness of the difficulties such patients face. The letter, edited to maintain patient anonymity, read as follows:

'I enjoyed reading your paper in the College Journal. I am a retired Consultant Physician. You may be interested in my medical history and you would be welcome to use my case if of interest to you. Briefly, I suffered from clusters of temporal lobe attacks for many years but for a variety of reasons was not treated with an anticonvulsant. I did not lose consciousness until a cluster in 1999/2000. At that time, I was recorded as having several episodes of asystole. However, I was not believed when I told the consultant looking after me in hospital that these were all preceded by symptoms consistent with temporal lobe seizures, particularly déjà vu in the form of unpleasant and incomplete recollection of strange dreams associated with distressing apprehension. A temporary pacemaker was inserted for the course of my admission. I was not started on an

anticonvulsant. On a subsequent admission, a while later, I happened to be managed by a different consultant who, upon hearing my story, sought the expertise of a neurophysiologist. I underwent simultaneous electroencephalography (EEG) and electrocardiography (ECG). These captured an event clearly demonstrating epileptiform EEG abnormality immediately prior to asystole, the longest period of which lasted 38 seconds! I have had a permanent pacemaker (PPM) since then and I also take lamotrigine. I have had no further episodes since 2003. My father had a PPM inserted in his early 70s but continued to have "funny turns", without loss of consciousness, which were not further investigated. He died at the age of 93. His brother had temporal lobe epilepsy but refused to take any anticonvulsants. He died two years ago aged 96. He did not have a PPM.'

This letter echoes many of the points made in our article and it is a timely reminder of the very real plight faced by patients suffering from ictal asystole. Chiefly, our article aims to educate physicians that careful attention should be paid to symptoms suggestive of focal seizures (e.g. déjà vu) in patients presenting with what otherwise sounds like syncope – they may have epilepsy presenting with ictal asystole. This letter demonstrates how the difficulties in recognising this can lead to a delayed diagnosis for many years, and emphasises the frustration patients can feel alongside this. This patient's case is particularly striking because of an apparent family history of similar problems. It would be interesting to investigate this further. Whilst we know that ictal asystole may be promoted by genetic conditions affecting cardiac conduction (ion-channel mutations),[2] actual cases of ictal asystole running within the same family are yet to be reported in the literature.

Gashirai K Mbizvo
Muir Maxwell Epilepsy Centre, Centre for Clinical Brain Sciences, The University of Edinburgh, Edinburgh, UK
Chris Derry
Department of Clinical Neurosciences, Western General Hospital, Edinburgh, UK
Richard Davenport
Department of Clinical Neurosciences, Western General Hospital, Edinburgh, UK
E-mail: gashirai.mbizvo@ed.ac.uk
doi: 10.4997/JRCPE.2020.230

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'Compassion' – an overused and out-of-context term in healthcare

Variation in the definition of compassion in relation to healthcare in medical literature is evident. The origin of compassion derives from the Latin *compati* – to suffer with. Interestingly, the Oxford dictionary defines it to be the 'sympathetic pity and concern for the sufferings or misfortunes of others'.[1] NHS England's Compassion in Practice defined compassion as care based on empathy, respect and dignity and described it as intelligent kindness.[2] Multiple high-profile exposés such as the Winterbourne View scandal in 2011 and the Mid-Staffordshire scandal in 2013 question whether practising compassion has been lost due to lack of its understanding and perhaps the pressures on current healthcare systems.[3,4]

An online six-question survey (Table 1) was sent to hospitals and medical schools in the United Kingdom, Europe, America, Asia and Africa. The survey was open for approximately 12 weeks to all members working in a healthcare environment. The most critical question was Question 6: 'Which one of the following phrases in your opinion best describes the term "compassion"?' with the following options provided:

- displaying kindness
- easing suffering
- showing pity
- being empathetic
- being considerate
- being thoughtful
- other (please specify)

The responses were pooled using Survey Monkey software. In addition, free text was analysed to look for particular themes. There were 323 responses suitable for analysis. The mean age-range of participants was the 18–25-year range. 71% of responders were female. 51% of responders were doctors or medical students, 14% were nurses, 14% administrative staff, 5% pharmacists, 4% were dieticians, physiotherapists or occupational therapists. 12% of respondents classified as 'other' included scientists and auxiliary staff.

The response to the most appropriate definition of compassion demonstrated that 42% associated compassion with 'showing empathy' while only 13% associated it with 'easing suffering'.

Analysing the free text responses from the study indicated that a number of participants felt that the definition could include several of the possible given options and indeed perhaps all of them e.g.:

> 'Compassion includes all of the above but is not equivalent to any one of them'

Table 1 List of questions asked in the survey

1	Are you male/ female /other?
2	Age range?
3	What is your role/occupation?
4	What is your grade?
5	Country you are working in?
6	Which one of the following phrases in your opinion best describes the term 'compassion'?

One interesting comment was:

> 'The Sanskrit word "karuna" - closest to compassion, is dynamic and is about doing an action to alleviate suffering. I go by this Indian perspective.'

This short survey emphasises that there is huge variation in the definition attributed to compassion by healthcare staff. The key finding was that the most popular definition of compassion was 'showing empathy'. Comments made in the survey suggest that for some people pity, empathy and sharing suffering are synonymous. This highlights the complexity of this term and perhaps its changing meaning over time, but also variations throughout the world across different cultural contexts. This study demonstrates the challenge in studying the understanding of compassion. Interviews may help in further understanding the concept, context and relationship to values around compassion. Institutions nurturing the value of compassion need to take responsibility for how it positions the value. Hence, active education about compassion in healthcare through Schwartz rounds and exploring the Healthcare Provider Compassion Model should be a vital aspect of training for upcoming healthcare professionals.[5,6]

Chaamanti Sivakumar
William Harvey Hospital, Willesborough, Ashford, UK
Nitin Ajit Kumar
Princess Roya University Hospital, Farnborough, Orpington, UK
Alexandra Merrett
Ashford and St Peters Hospital, Chertsey, UK
Sunil Bhandari
Hull University Teaching Hospital NHS Trust, Hull Royal Infirmary, Hull, UK
Email: Sunil.bhandari@hey.nhs.uk
doi: 10.4997/JRCPE.2020.231

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COVID-19 and Rapid Research Translation: universal masking as a case study

The past few days have shown us how research can be translated rapidly into practice in times of great need. No more clearly is this shown than by the recent recommendations by the World Health Organization (WHO), Center for Disease Control (CDC) and other government bodies worldwide on the use of universal masking in public against COVID-19. This is a reversal from previous statements made as recently as 30 March 2020 by the WHO on limiting masks to symptomatic individuals, despite a survey from China, which has to a significant extent contained COVID-19, showing that 98% of residents in Hubei wear masks when going out, as recommended by the Chinese CDC.[1] Examining this reversal further, we can underpin two main recent developments that allowed this to take place: firstly, evidence from China[2] and Germany[3] suggesting the potentially large proportion of asymptomatic individuals and potential transmission from asymptomatic individuals; secondly, and most importantly, the laboratory study conducted by Bourouiba from the Massachusetts Institute of Technology provides a reminder that droplets can travel distances as great as 7–8 metres,[4] which makes recommended physical distancing of two metres moot.

Previous statements on wearing masks in public as being 'not effective' clearly lack scientific underpinning, but the scarcity of personal protective equipment (PPE) even today is certainly a barrier to reversing this statement. This is where previous studies of the efficacy of homemade masks against influenza and a third study by Ma et al. comparing the efficacy of N95 masks, medical masks and homemade masks (made out of fours layers of kitchen paper and one layer of cloth) against the avian influenza come into play. Ma et al. reported a high efficacy in blocking virus in aerosols made by a nebulizer of 99.98%, 97.14% and 95.15% for N95 masks, medical masks and homemade masks respectively.[5] These studies provide some new evidence of efficacy, albeit limited to recommending the use of homemade masks for the public, thus relieving the additional burden on PPE supply.

This move towards scientific evidence as a basis for public health action is certainly a welcome respite against the current onslaught of COVID-19 infodemics and microeconomics as the basis for decision-making. The move towards low cost but high value recommendations, such as universal masking, is also important in supporting flattening and shortening the curve globally.

Anthony Paulo Sunjaya
The George Institute for Global Health, UNSW Sydney, Australia
Email: a.sunjaya@unsw.edu.au
doi: 10.4997/JRCPE.2020.232

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COVID-19 epidemic: cocoon the elderly and the vulnerable

'Hide your grandpas and grandmas' said the Israeli Government[1] to the public, responding to the COVID-19 threat; a simple, sensible and succinct message.

During epidemics of contagious diseases, conventionally the infected are quarantined to prevent spread to the healthy, who are then free to go about normal work and business. In the COVID-19 pandemic, worldwide mortality graphs show the case-fatality rate increasing progressively from age 55 and peaking at about 15%[2] in those above age 80. Mortality is also high in subjects vulnerable due to comorbid non-communicable diseases[3] and higher still when the elderly have chronic diseases.

Judging by the dynamics of pandemics,[3,4] before the SARS-CoV-2 pandemic is over, about 50–70% of the population in most countries are likely to get infected and become immune; infection may be occult or overt.[5] These immune individuals will be mostly young people who would have had mostly asymptomatic or mildly symptomatic disease.[6] Those who develop COVID-19 are likely to have a self-limiting respiratory illness.

However, infected youngsters are likely to pass on the infection to the old and vulnerable members within the family. If the elderly and the vulnerable are isolated from others during this epidemic, they have a good chance of escaping infection altogether. Such isolation, for their safety, is 'reverse quarantine' or 'cocooning'. They must await the decline of the epidemic and/or an effective vaccine becoming available, before cocooning is lifted.

How do we practise cocooning? All those steps you want a SARS-CoV-2-infected person to take in order to prevent spreading the infection, you ask the elderly and vulnerable to practise in order to avoid getting infected!

These measures include confining themselves to home, wearing a mask all the time while in the presence of family members or home help, remaining socially connected only through the telephone and social media, frequent and thorough handwashing after touching objects likely to have been touched by others, using disposable gloves or a napkin hand-cover when opening a door or pressing a lift button, avoiding shared mobile phones and keeping toilet articles separate. All their physical and emotional needs should be met by family members, and all public utilities, medicines and services delivered at home. Their rooms and bathrooms should be sanitised periodically with dilute bleach (sodium hypochlorite) solution or soap and water, making sure the floor is mopped dry to avoid slips and falls.

Home entertainment, indoor games, reading, painting, gardening, listening to or playing music will be worthwhile pastimes. Interactions with children, who may bring infection home, should be with a mask on, children also wearing masks and maintaining the critical physical distance of two metres. Caretakers of cocooned people should be young (age <40), wear a mask all the time, and wash hands thoroughly before and after physically helping. In the event of a febrile illness in themselves or their family members they should abstain from work for four weeks (from the day of recovery).

During this global public health emergency, people of all nations wait for guidance. 'Cocooning the elderly and vulnerable' may be a practical and effective motto to protect them from SARS-CoV-2 infection!

MS Seshadri
Honorary Medical Director and Consultant Physician, Thirumalai Mission Hospital , Ranipet, Vellore, India
T Jacob John
Former Professor and Head of Clinical Virology, CMC Hospital, Vellore, India
Email: mandalam.seshadri@gmail.com
doi: 10.4997/JRCPE.2020.233

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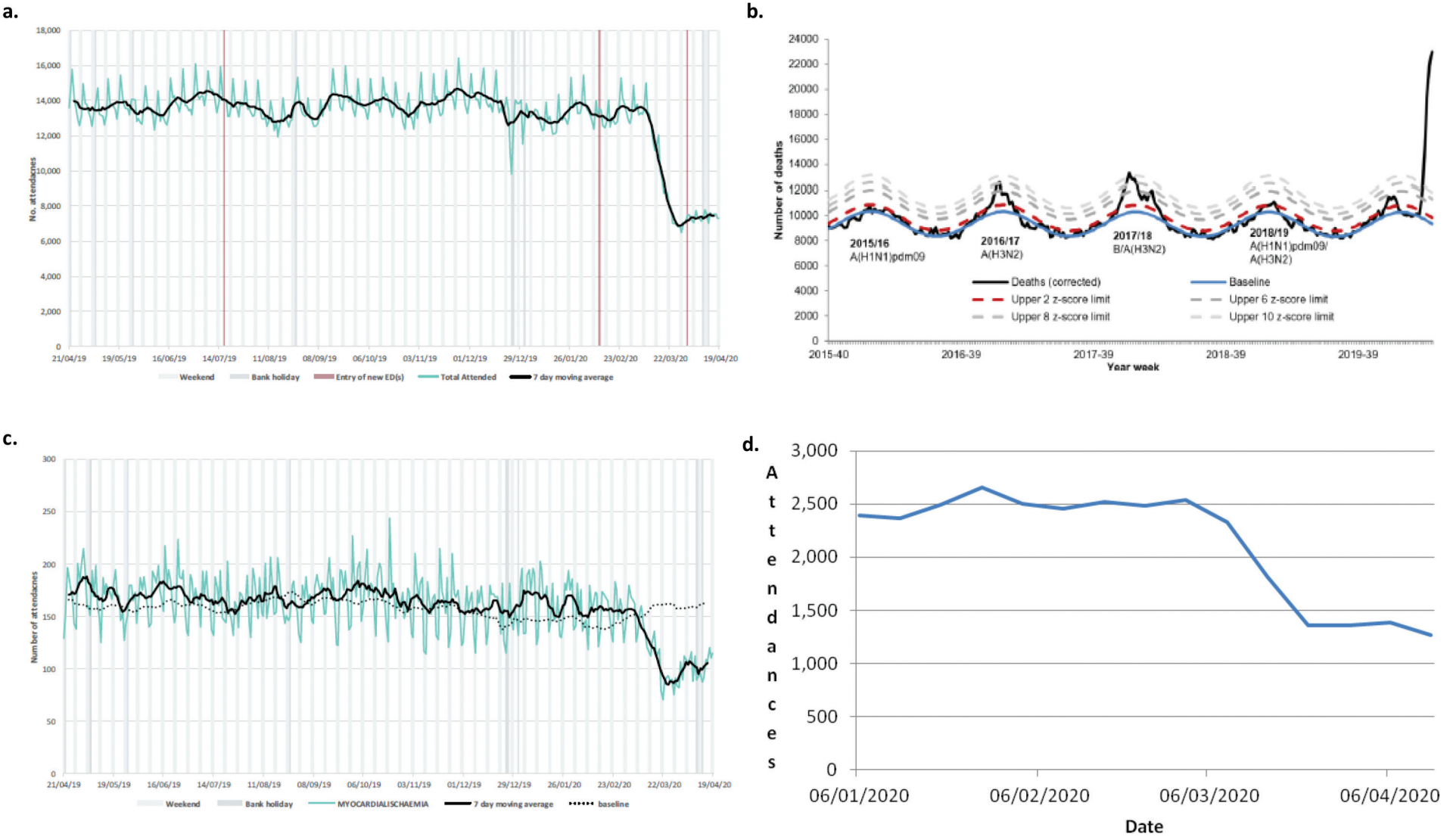
Falling usage of hospital-based emergency care during the COVID-19 pandemic in the UK

As a research fellow in renal medicine and a consultant redeployed to full-time clinical work, we would like to thank RCPE for its informative, useful and balanced weekly COVID-19 webinars. Now as a doctor on a 'cold' medical admissions unit (MAU) in a tertiary teaching hospital in the north of England would like to offer our, perhaps less typical, experience of the COVID-19 pandemic so far.

Our once overstretched 45 bed MAU now rarely finds more than 50% of its capacity being used. At our hospital and also nationally, rates of attendance at A&E have dropped drastically since the onset of the pandemic (Figure 1a and d), in the face of a greatly increased but unsurprising all-cause mortality (Figure 1b). Although we welcome part of this decrease in A&E attendance as a more appropriate use of

Figure 1 Data trends prior and during the COVID-19 pandemic. A. National daily attendances to A&E departments April 2019 to week ending 19/4/2020. Black line-7 day moving average. B. Weekly observed and expected number of all cause deaths in all ages, with the dominant circulating influenza A sub type below, England,2015 to week ending 19/4/2020. Black line- deaths (corrected), Blue line-baseline predicted deaths. C. National daily of attendances recorded as myocardial ischaemia attendances April 2019 to week ending 19/4/2020. Black line- 7 day moving average, Dotted black line-baseline predicted attendances. D. Weekly attendances at HUTH A&E department week commencing 6/1/2020 to 6/4/2020. **Sources:** A and C: Emergency Department Syndromic Surveillance System Bulletin. Year 2020, week 16. B: Immunisation & Countermeasures Division, National Infection Service, Public Health England, All-Cause Mortality Surveillance, week 17 report. D: Activity data, the Hull University Teaching Hospitals NHS Trust Business Intelligence portal.



emergency services, we find ourselves wondering what has become of the 'bread-and-butter' medical admissions that used to fill our beds, such as myocardial infarctions, strokes and gastrointestinal bleeds. We note the particularly striking data showing the reduction in attendances due to myocardial ischaemia (Figure 1c). The British Heart Foundation has also highlighted a 50% drop in admissions for suspected myocardial ischaemia from 300 to 150 patients per day nationally.[1] A survey of six London percutaneous coronary intervention centres showed a 38% reduction in the number of procedures performed since the beginning of the pandemic.[1] The Academy of Medical Royal Colleges (AoRC) has advised patients and the public of the vital importance of continuing to seek medical assistance if they are worried about themselves or others.[2] They state that patients must not hold back from accessing help for emergencies, poorly controlled or unstable long-term conditions or for the provision of palliative and end-of-life care.[2] In the four weeks since the onset of the pandemic the number of deaths occurring nationally in private homes has increased 51.1% (from 2725 to 4117 deaths, a rise of 1392) compared to a 72.4% increase of deaths seen in hospitals.[3] This statistic appears unremarkable given the increase in all-cause mortality; however, of home deaths, only 8% (330) were attributed to COVID-19. Therefore, barring misclassification, there has been an increase of 1062 (1392 minus 330) people dying at home from causes other than COVID-19 in the four weeks of the pandemic so far.[3]

In our renal medicine role, we have also seen specialist nurses and consultants labouring to reorganise vital elective services, including the monitoring and treatment of renal anaemia and post-transplant care. Monitoring has been reduced to perhaps suboptimal levels, important treatments delayed and some specialist staff redeployed to other duties.

A number of advisory committees and experts have warned of the harm that can be caused by the undetected deterioration in chronic health conditions that may occur during this pandemic as a side effect of diverted resources.[1,2,4–6] These papers suggest a number of strategies to mitigate the effect of the pandemic such as greatly increasing use of telemedicine, delaying screening procedures and increasingly explicit conversations with patients regarding the risks and benefits of given treatments.[4–6] The risks of deviating from the standard of care should be carefully weighed against the risk of COVID-19 infection.[4] Decisions should be based on evidence not fear.[5] Previous pandemics have shown us that there is a danger of increased harm to patients by them not seeking medical treatment due to fear or concerns about putting strain on an overstretched system.[2] As the AoMRC states we must remind patients that even during a pandemic hospitals are safer than their homes if they require emergency care.[2]

Richard Bodington, Sunil Bhandari
Department of Renal Medicine, Hull University Teaching Hospitals NHS Trust and Hull-York Medical School, University of Hull, Hull, UK
Email: r.bodington@nhs.net
doi: 10.4997/JRCPE.2020.234

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Challenges to scientific publishing in times of COVID-19

The ongoing SARS-CoV-2 (COVID-19) pandemic has thrown up challenges to all of us, including to the field of scientific research and publishing. The clinicians on the frontline are looking expectantly at the outcomes of research to guide their decision making. This rapidly evolving scenario has pressurised journals to shorten the time to publication. The editors have been tasked with sifting through the ever increasing COVID-19-related submissions and at the same time ensuring timely processing of non-COVID manuscripts. Adhering to the principles of publishing while still looking for innovative solutions would serve the scientific community well in such situations in the future.

The pandemic has generated huge interest among researchers, and preprint servers like bioRxiv and medRxiv have been flooded with COVID-19-related (mostly non peer-reviewed) manuscripts. These servers usually play a significant role in advancing science by way of making raw, unpublished data available to other researchers. The data presented in the manuscripts placed in such repositories demands careful interpretation. However the conclusions of these studies (often sweeping and sensational) are now being circulated widely in social media and picked up by news outlets.[1]

Publication of research in a reputed journal gives credence to the work. This implies that the quality of science that gets published is not being compromised. Inappropriate conclusions and extrapolations on the other hand can be disastrous. They may convey false messages which, in these times when the world is looking for more and more information, can spread very quickly.[2] Meticulous editorial and peer review cannot therefore be bypassed in favour of reducing time to publication.

A recent example is a study from China which reported that of 1,590 COVID-19 patients, 18 (1%) had a history of cancer,

which was higher than the overall incidence of cancer in China (0.29%). The supplementary data showed that not all 18 COVID-19 cancer patients were receiving cancer treatment. Some had inactive cancers or were on routine follow-up post-surgery. The data of the study seemed important enough to be shared, but with only 18 cancer patients in the study population, a conclusion that 'patients with cancer might have a higher risk of COVID-19 than individuals without cancer' appears to be an overstatement.[3]

Yet another challenge for journals is the availability of some of their editors and reviewers. With schools shut and children at home, some need to devote more time to their families. Others who are on the frontline in the fight against COVID-19 are able to devote less time to editorial and peer-review work.[4] On the other hand, with most non-emergency healthcare deferred in some countries, certain editors and reviewers may be able to give more time to journal work. Journals may be served well by maintaining constant communication with their editors and reviewers, inquiring about their availability, and allocating work accordingly.

With 'shelter in' orders in place in many countries, researchers could use the extra time at their disposal to complete and submit their manuscripts. While the bulk of the focus of the scientific community remains centred on COVID-19, journals must ensure that non-COVID science is not neglected. Due to closed workplaces (laboratories and non-emergency clinics), reviewers may consider carefully the need to ask the authors to carry out additional research or collect additional data.[5] Our conduct in these unprecedented times and the response to these challenges could enhance or diminish the reputation of scientific research and publishing.

Mohit Goyal
Consultant, Division of Rheumatology, CARE Pain & Arthritis Centre, Goyal Hospital, Udaipur, India
Email: dr.mohitgoyal@gmail.com
doi: 10.4997/JRCPE.2020.235

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A few points about indwelling pleural catheters

We thank Currie et al. for the recent paper on indwelling pleural catheters (IPCs).[1] We run a large pleural service in north east of England,[2] and have recently presented our outcomes regarding 98 IPCs from 2015 to 2018.[3] As Currie et al. suggest, complications are very low in established centres. We also agree absolutely with the points that patients need to have a clear point of contact, that most infections can be managed with antibiotics without IPC removal and that IPCs do not preclude chemotherapy.

However, we would like to point out that we follow the well-established Best Practice Tariff programme in our Trust,[2] where, unless significantly breathless, a patient presenting acutely is brought back to an ambulatory care setting or an urgent clinic where a therapeutic aspiration is performed and a referral for a more advanced procedure (medical thoracoscopy/IPC) is made. As such, the 'traditional management' of a suspected or confirmed malignant effusion is not an intercostal chest drain insertion: practice will vary significantly across the United Kingdom and perhaps a reference should be made towards that.

Currie et al. make a very good point that general physicians should also know that IPCs exist and that they should also perhaps learn to manage them. Over time, articles such as theirs and training programmes will help with that. We have produced a local troubleshooting guide (Annexe 1, available online only) and share it in this letter, in the hope that it can be widely applied.

Another very important point made by Currie et al. is the training of other staff to place IPCs. As long as the same governance process can be applied, this can be a very successful venture. Locally, we have adapted the technique for pleural catheters to insert peritoneal ones.[4] With the development of that service, we have trained one acute medicine staff grade doctor to insert both pleural and peritoneal catheters, and a gastrointestinal surgeon who only does the latter. The IPC service is coordinated by a pleural Fellow, who is appointed on a yearly basis. Plans are afoot to train community palliative care nurses as well as specialist lung cancer nurses to perform pleural and/or abdominal ultrasonography and hopefully to train them to do pleural and/or peritoneal procedures in the future. We already have a senior sister on the oncology day unit who can perform pleural aspirations and we also hope to develop her skill sets further.

Hence, again, we congratulate Currie et al. on their succinct paper on IPCs and hope that this correspondence will complement it.

Avinash Aujayeb
Consultant in Acute and Respiratory Medicine, Northumbria HealthCare NHS Foundation Trust
Karl Jackson
Pleural Fellow, Northumbria HealthCare NHS Foundation Trust
Email: avinash.aujayeb@nhct.nhs.uk
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Authors' reply

We thank Drs Aujayeb and Jackson for the comments regarding our recent editorial[1] and feel their insights and experiences greatly add to the general discussion about the use of indwelling pleural catheters (IPC) in everyday life. In particular, we applaud them for highlighting their bespoke pathway by which individuals presenting with a large pleural effusion undergo initial therapeutic aspiration followed by referral for either an IPC or medical pleurodesis via chest drain. The validity for this practice is borne out by the AMPLE randomised clinical trial whereby using an IPC versus 'traditional' talc pleurodesis resulted in fewer hospital admission days from treatment to death plus fewer ipsilateral pleural drainage procedures.[2] We also thank them for their willingness to share their 'troubleshooting guide' with readers of the Journal. Lastly, we agree that training surrounding IPC insertion does not necessarily need to be tailored entirely to clinicians, and that other healthcare professionals, such as experienced nurses or physician associates, may be suitably positioned to acquire such skills.

Mahendran Chetty, Graeme P Currie
Consultant Chest Physicians, Chest Clinic C, Aberdeen Royal Infirmary, Foresterhill, Aberdeen, AB25 2ZN, UK
Email: Graeme.currie@nhs.net

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