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END-OF-LIFE COMMUNICATIONS

We read with great interest the editorial article titled 'End-of-life communication: let's talk about death.'[1] 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.[2] 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.[3] 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 early enough the importance of honest communication with the patient, emphasising that the provision of timely and appropriate information can positively enhance rather than diminish patients' hopes.[4]

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I read the editorial on end-of-life communication[1] with interest and warm appreciation, having had recent family experience of prime end-of-life care, and an earlier professional interest in the teaching of communication skills.

Among the journals referenced, the name Psycho-Oncology caught my eye, and sparked a train of speculation. Subspecialisation has been at the heart of medical advances in knowledge and care. But the title 'Psycho-Oncology' appears to rest on a Cartesian division, segregating mental from physical issues within the specialty. While such a subspecialty journal provides a platform for what seems to be a minority interest within a specialty, would it be a desirable trend for more specialty '-ologies' to develop an appendage – 'psycho-ology'? Might then the unintended consequence be that this disassociation of mind and body in turn excused the mainstream from any serious concern other than the physical aspects of ill health? And what merit would there be in an '-ology' involved with the soma alone?

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

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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 thrombocythaemia.

Potassium is released from platelets during clot formation.[1] 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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