Bronchiectasis

Dear Editor

The well researched article by Maguire[1] (*AFP* November 2012) mentions hypogammaglobulinaemia as a potential cause of bronchiectasis but has not commented on the usefulness of IV immunoglobulin replacement for such patients. Patients with chronic lymphocytic leukaemia, particularly those treated with rituximab and who develop recurrent sino-bronchial infections are prone to developing bronchiectasis and may deserve a trial of IV mmunoglobulin.[2,3]

Dr Ram Tampi
Clinical haematologist
Perth, WA

References

1. Maguire G. Bronchiectasis. Aust Fam Physician 2012;41;842–50.
2. Boughton BJ, Jackson N, Lim S, et al. Randomised trial of IV Ig prophylaxis for patients with lymphocytic leukaemia. Clin Lab Haematol 1995;17:75–80.
3. Freeman JA, Crassini KR, Best OG. Immunoglobulin G subclass deficiency and infection risk in 150 patients with chronic lymphocytic leukaemia. Leuk Lymphoma 2013;54:99–104.

Reply

Dear Editor

Dr Tampi makes a valid point and highlights that the development of symptoms of bronchiectasis in such patients should warrant investigation for gammaglobulin replacement. A point worth highlighting to primary care practitioners, as such patients are being increasingly encountered.

Dr Graeme Maguire
Alice Springs, NT

End-of-life decisions

Dear Editor

We read with interest the article by Gaw and colleagues[1] (*AFP* August 2012) highlighting the limited prevalence of documented advance care plans (ACPs) in patients presenting to, and dying in, acute hospitals. As the authors highlight, despite widespread promotion and evidence outlining the benefits of advance care planning[2] uptake remains low. We wish to share findings from a study we conducted in a large Australian metropolitan teaching hospital, one that reveals similar findings.

We conducted a retrospective review of 90 consecutive inpatient deaths at the Royal Melbourne Hospital, to ascertain documented preparedness for end-of-life care with focus on prevalence of documented ACPs and Limitations of Medical Treatment Orders (LOMT). This audit was approved by the Melbourne Health Human Research Ethics Committee.

Of 90 patient deaths, only three patients had a documented ACP. The ACP varied between patients, with two case notes recording a family meeting where the previously expressed wishes of the patient were documented, and one containing a copy of patient enacted ACP.

During the final admission, there was a high incidence of formal LOMT (80%), with the average time from admission until documented LOMT being 4.9 days. Of the 18 patients who died without LOMT, seven were aged less than 50 years, and a further nine died following unsuccessful resuscitation attempts following cardiac arrest. A small proportion of LOMT forms (15%) were enacted following a 'code blue' or medical emergency team call.

Only 14% of patients were documented to be involved in the discussions regarding their own LOMT. There was no statistically significant relationship between English language proficiency and involvement of patients in LOMT decisions.

Given evidence revealing poor correlation between clinician and patients and their wishes, particularly for end-of-life care,[3] we support Gaw's calls for greater clinician understanding of their role in assisting patients to complete an ACP and highlight the key role GPs have, in partnership with acute hospitals, to see this process completed and available to clinicians when needed.

Dr Joanna Mitropoulos
Dr Brian Le
Department of Palliative Care
The Royal Melbourne Hospital, Vic

References

1. Gaw A, Doherty S, Hungerford P, May J. When death is imminent: documenting end-of-life decisions. Aust Fam Physician 2012:41:614–7.
2. Detering KM, Hancock AD, Reade MC, Silverster W. The impact of advanced care planning on end-of-life care in elderly patients: randomised clinical trial. BMJ 2010;340:c1345.
3. Downey L, Au DH, Curtis JR, Engelberg RA. Life-sustaining treatment preferences: matches and mismatches between patients' preferences and clinicians' perceptions. J Pain Symptom Manage 2012 Sep 24 pii: S0885–3924(12)00363–6. [Epub ahead of print].

Emergency management of anaphylaxis

Dear Editor

The advice on the emergency management of anaphylaxis[1] (*AFP* January/February 2013) was adapted from an article published in 2006. In 2011, Australian Prescriber published a wallchart[2] of emergency management with the assistance of the Australasian Society of Clinical Immunology and Allergy. This chart was endorsed by several colleges, including The Royal Australian College of General Practitioners.

The chart is available on the Australian Prescriber website (austalianprescriber.com) and we still have a few laminated copies of the A3-sized wallcharts. If any *AFP* readers would like a wallchart for their treatment rooms, please contact the Australian Prescriber office on info@australianprescriber.com or telephone 02 6202 3100.

John Dowden
Medical Editor, Australian Prescriber

References

1. Laemmle-Ruff I, O'Hehir R, Ackland M, Tang MLK. Anaphylaxis: identification, management and prevention. Aust Fam Physician 2013;42:38–42.
2. Anaphylaxis wallchart. Available at www.australianprescriber.com/magazine/34/4/artid/1210 [Accessed 18 February 2013].

Letters to the Editor

Letters to the Editor can be sumitted via:
E-letters: www.racgp.org.au/afp
Email: afp@racgp.org.au
Mail: The Editor, Australian Family Physician
100 Wellington Parade
East Melbourne VIC 3002 Australia