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Making every contact count: the role of the clinician in smoking cessation during the perioperative period

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Editor – We read the paper by Durrand *et al* about setting up prehabilitation services with interest and would like to highlight our learning and insight from a local smoking cessation service for perioperative patients.[1]

Smoking is an independent predictor of postoperative complications, and modifications have shown to improve outcomes after surgery.[2] The perioperative period can be an auspicious time to address risk-taking behaviours, like smoking, as patients may be more receptive to making positive changes that can impact their health.[1] Clinicians can play an important role in patient behavioural change by using strategies like Making Every Contact Count (MECC).[1,3]

Smoking has been recognised as the main cause of preventable illness and premature mortality in England and is associated with increased perioperative risk and delayed postoperative recovery.[4,5] Smoking cessation advice and referral has been shown to be cost effective in helping people quit and is an intervention that lends itself well to MECC.[6] Clinicians who are involved in perioperative care can be key personnel in delivering lifestyle advice and referring patients to smoking cessation services.

Yet despite these health risks, nationally there has been a decline in using smoking cessation services and prescriptions for nicotine replacement therapy.[4] In our hospital trust, we found that of 122 patients reviewed in preoperative clinic, 21% (26), were identified as smokers. Of those patients, 65% (17/26) were offered a referral to smoking cessation services of which 76% (13/17) declined. With a 59% attendance rate following acceptance of referral, only 8% (2/26) of smokers seen prior to surgery engaged with smoking cessation services. Some of the barriers to successful referral encountered were lack of behavioural modification training among staff and a significant proportion of patients declining referral when given the option of attending.

The National Institute for Health and Care Excellence recommends that patients who smoke and are planning to have surgery should be referred directly to smoking cessation support services. This opt-out model should be part of routine care and staff should be equipped with the skills to deliver this service.[6] Hence, we suggest training in MECC and behavioural modification should be incorporated into postgraduate medical and nursing training. ■

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Trends in recruitment into core medical training in the UK – could doing quality improvement projects help?

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Editor – Butterworth and colleagues highlight the problems of recruiting and retaining enough medical trainees.[1] They also mention there is a similar crisis in general practice. As medical students who were recently encouraged to become general practitioners (GPs) by conducting quality improvement projects in primary care, we would like to share what we learned. We hope it might be of interest to medical specialties.

To start with, we looked at a range of audits that might be useful to the practice and chose topics based on personal interest. We found it exciting for us as students to have the possibility of influencing clinical practice and improving patient care. This made our projects more enjoyable in terms of academic learning.

We found general practice was a friendly and supportive environment for carrying out an audit. Learning how to create our own databases and doing simple statistical analysis made us feel more confident about carrying out future audits exploring the gaps between guidelines and practice.

We discovered a common theme in our audits – the tension between adhering to national guidelines and feasibility in busy, everyday practice. An example of this was one of our audits looking at whether GPs comply with National Institute for Health and Care Excellence guidelines to screen patients with

low folate for coeliac disease. With so many patients with low folate, it seemed that clinicians relied on clinical judgement to decide investigation and management plans, often not following guidelines precisely.

This was further exemplified in the audit investigating how often women were given appropriate advice on diet and exercise in their post-natal checks, where we also reflected on the struggle between the doctor's and the patient's agenda. During these sensitive but time-limited appointments, doctors had to decide what information to focus on, balancing patient preference and clinical judgment.

Lastly, carrying out projects such as in our questionnaire survey, showed us how patients differ in their ethnicity, age and body mass index; and how demographic parameters can impact the GP's approach.

It has been suggested that students do not perceive general practice as an academically challenging career choice.[2] Conducting quality improvement projects can change this perception.

In their conclusions, Butterworth and colleagues describe important initiatives to enhance the attractiveness of medical specialties.[1] Perhaps quality improvement projects for students supervised by an enthusiastic physician role model could also be considered. ■

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Upper gastrointestinal bleeding in superior mesenteric vein thrombosis

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Editor – We have read the case report and accompanying literature review entitled 'Upper gastrointestinal bleeding in superior mesenteric vein thrombosis' by Phyu *et al* with great interest.[1] Although we agree with the authours review of the literature, we feel there is more to consider in cases like this based on our experiences in a tertiary hepatology centre.

In the discussion points it is rightly pointed out that recanalisation of the superior mesenteric vein in the acute setting is vital. However, the authors go on to argue that mechanical thrombectomy 'should only be considered if the patient's condition continues to deteriorate despite anticoagulation' and surgery should be considered if there is evidence of bowel ischaemia.

It is important to note that surgical intervention is associated with worse short and long-term outcomes and prolonged hospital stays.[2] Intestinal infarction and bowel necrosis necessitating surgery is an endpoint that would indicate end-organ damage and treatment failure and therefore should be avoided.

As is the case with other acute, thromboembolic conditions such as pulmonary emboli and ischaemic strokes, it is recognised that medical thrombolysis may be able to achieve recanalisation more rapidly and improve outcomes in carefully selected patients.[3,4]

Experience at a tertiary centre with thrombolysis in acute splanchnic vein thrombosis (SVT) has recently been published.[5] The 22-patient case series highlights the potential role of tissue plasminogen activator and local clot dissolution therapy in preventing surgery. This approach may be indicated in patients with features of uncompensated bowel ischaemia as evidenced by clinical (eg poor resolution of abdominal pain, peritonism), biochemical (eg progressive lactataemia) or radiological (eg bowel loop dilatation or oedema) grounds. A step-wise thrombolysis protocol and early referral to a specialist hepatology centre should have a role in the treatment protocol for patients with SVT. ■

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