Dying for palliative care

EDITOR,—It seems appropriate that articles communicating poor recognition of the palliative care philosophy should have space “afforded” to them.¹ They emphasise the crisis in caring for dying people despite the creation of a specialty and reiterate results of other studies showing that patients are still dying unprepared and suffering.² The reason for this is twofold.

Firstly, there is still a reluctance to inform patients with cancer of their diagnosis and, through a process of informed consent, to negotiate the appropriateness of active treatment.³ Greater emphasis should be placed on distinguishing between cure and care. Furthermore, cure should not be perceived as the only successful outcome of treatment, with anything less as failure.

Secondly, a deficit in training exists, which is exacerbated by an inappropriate reliance on specialists in palliative medicine. Most patients do not die in hospices, and so the philosophy of care is most frequently practised by inadequately prepared generalists in the community and hospitals.

Dying remains a taboo subject, and the recent articles and correspondence convey a message: where is palliation, dignity, and death as a normal part of the life cycle? In addition, why do some doctors avoid admitting that a patient is dying and why are they reluctant to provide sufficient symptom control?

Training in palliative care, for both undergraduates and postgraduates, must be urgently addressed to prevent continuing suffering of terminally ill patients who are not in hospices. As the head of the Cancer and Palliative Care Unit at the World Health Organisation's headquarters, Dr J Stjernsward, stated, “Nothing would have more immediate effect on quality of life and relief from suffering, not only for cancer patients but also for their families, than implementing the knowledge accumulated in the field of palliative care.”⁴

RODGER CHARLTON
Senior lecturer in primary health care

School of Postgraduate Medicine,
University of Keele,
Department of Primary Health Care,
North Staffordshire Hospital,
Stoke on Trent ST4 7QB

- 1 Snaith RP. Dying for palliative care. *BMJ* 1995;10:529. (25 February.)
- 2 Mills M, Davies HTO, Macrae WA. Care of dying patients in hospital. *BMJ* 1994;309:583-6.
- 3 An open letter to my surgeon. *BMJ* 1992;305:62.
- 4 MacDonald N. Priorities in education and research in palliative care. *Palliat Med* 1993;7(suppl 2):65-76.

Computed tomography in first uncomplicated generalised seizure

Should be performed irrespective of any history of alcohol misuse

EDITOR,—Ronald A Schoenenberger and Sabine M Heim draw conclusions about the investigation of a first generalised seizure that may not be generally applicable to patients seen in an accident and emergency department.¹ The CAGE questionnaire may or may not be a fair means of assessing alcohol dependence in English speaking respondents and may be less reliable when translated into another language (what is the German for “eye opener” anyway?).

Thirteen patients were excluded because computed tomography was not performed, in six cases because the patients refused to consent to it. Did they refuse scanning because of local brain lesions causing altered behaviour? While no patient answering “yes” to two or more questions on the CAGE questionnaire had a focal brain lesion, two

had potential additional causes for their seizure other than alcohol withdrawal, which in one case was a disorder of the central nervous system. One of the dangers of this paper is that it will discourage the search for other potentially important causes of a seizure in patients who are perceived to be dependent on alcohol—for example, HIV encephalopathy, as found in this study.

The fourth point in the box containing clinical implications states that “patients without neurological symptoms and who did not misuse alcohol did not have focal lesions on computed tomography.” In fact, 20 patients in this group had focal lesions on computed tomography.

It is also stated that, by not offering computed tomography to patients on the basis of lack of focal lesions and probable alcohol withdrawal, it “would thus greatly reduce the number of scans that yield no positive diagnosis.” It would reduce the number of scans by about a third, which is a minority.

We think that this paper is misleading in suggesting that we can reliably determine patients who will not have focal lesions by computed tomography by neurological examination and use of the CAGE questionnaire. Computed tomography should probably be offered to all patients who present with a first seizure, whether they misused alcohol or not. Whether computed tomography needs to be performed within the first 24 hours or can safely be left longer in the absence of further seizures was not addressed by this study.

ALASTAIR HAY
Senior house officer
MICHAEL BALL
Research registrar

Department of Neurology,
Royal Hallamshire Hospital,
Sheffield S10 2JF

- 1 Schoenenberger RA, Heim SM. Indication for computed tomography of the brain in patients with first uncomplicated generalised seizure. *BMJ* 1994;309:986-9. (15 October.)

Should always be performed

EDITOR,—In their prospective series of 119 patients admitted after a first seizure Ronald A Schoenenberger and Sabine M Heim found that no focal lesion would have been missed if computed tomography had been performed only in patients who either presented with a focal deficit or did not misuse alcohol and did not have a focal deficit.¹ They conclude that although computed tomography of the brain remains necessary in most patients after a first seizure, it may not be absolutely necessary in patients who have uncomplicated seizures related to alcohol and in whom neurological examination yields normal findings.

We retrospectively reviewed the records of 247 adults admitted to our emergency unit after a first generalised seizure.² Criteria for inclusion were nearly the same as those in Schoenenberger and Heim's study. In every case neurological examination had been performed by a senior physician and computed tomography of the brain had been performed. The characteristics of our population were similar to those of Schoenenberger and Heim's patients. Alcohol dependence was the only cause in 49 patients (alcohol withdrawal in 37 of them) and was at least a cofactor in 91 patients. Indeed, alcohol dependence was ascertained in 42 patients in whom the cause was cerebral haemorrhage (eight), infarction (10), tumour (six), metabolic disturbance (six), drug intoxication (six), and cranial trauma (six). Thus the rate of focal lesions among patients dependent on alcohol was 25% (24 patients). In patients in whom the result of neurological examination was normal the rate of focal cerebral lesions was significantly higher in those who were not dependent on alcohol than in those who were (24/109 v 6/70, $\chi^2=5.525$, $P=0.019$). Nevertheless, the rate of focal lesions in

the patients dependent on alcohol in whom the results of the examination were normal—9%—is not negligible. Indeed, if in patients dependent on alcohol the absence of a focal deficit had been considered to be a reliable criterion of absence of brain damage, early diagnosis of six focal lesions—two infarctions, one haemorrhage, one glioblastoma, and two subdural haematomas—would have been missed.

In conclusion, in accordance with previous reports^{3,4} and our experience, we believe that computed tomography should always be performed in patients presenting after a first seizure, even those presenting with chronic alcohol dependence in whom the result of neurological examination is normal.

P LAFOND

B TARDY

F ZENI

A VIALLO

Y PAGE

Consultants in emergency medicine

J C BERTRAND

Professor of medicine

Emergency and Intensive Care Department,
Hôpital Bellevue,
CHU Saint Etienne,
42055 Saint Etienne Cedex 2,
France

- 1 Schoenenberger RA, Heim SM. Indication for computed tomography of the brain in patients with first uncomplicated generalised seizure. *BMJ* 1994;309:986-9. (15 October.)
- 2 Tardy B, Lafond P, Convers P, Page Y, Zéni F, Viallon A, et al. Adults first generalised seizure: etiology, biological tests, electroencephalogram, computed tomographic scan, in an emergency department. *Am J Emerg Med* (in press).
- 3 Ramirez-Lassepas M, Cipolle RJ, Morillo LR, Gummit RJ. Value of computed tomographic scan in the evaluation of patients after their seizure. *Ann Neurol* 1984;15:536-43.
- 4 Sempere AP, Villaverde FJ, Martinez-Menendez B, Cabeza B, Pena P, Tejerina JA. First seizure in adults: a prospective study from the emergency department. *Acta Neurol Scand* 1992;86:134-8.

Is grossly oversold

EDITOR,—Ronald A Schoenenberger and Sabine M Heim conclude that “both the diagnostic yield and the resulting interventions justify computed tomography of the brain in most adult patients in casualty departments who have had a first generalised seizure,” but their evidence does not support this statement.¹ They found a particularly high proportion of cerebral tumours, possibly because only patients over the age of 16 were included in the study. In the national general practice study of epilepsy a definite cause for seizures could be ascertained in only 61% of 564 patients; in only 6% of cases were the seizures due to cerebral tumour.² We believe that this is more representative of the true incidence of symptomatic epilepsy in a population. The authors also included patients with intracranial haemorrhage and physical signs in their first study, when other patients were excluded because “clinical circumstances allowed the definite cause of the seizure to be diagnosed.” A further anomalous point is that two patients who were said to have idiopathic epilepsy had focal neurological deficits.

The authors present their data in a way that grossly oversells the value of computed tomography after a first seizure. Subtraction of the fifth from the second columns of the authors' table I shows that only 13 of the 119 patients had a focal lesion on scanning without physical signs. In one of these, the patient with a viral encephalitis, a neurological deficit was apparent on examination but the scan was normal. It may fairly be said, therefore, that in this series computed tomography found a focal lesion unaccompanied by physical signs in 12 of the 119 patients. The number of patients in whom interventions are likely to have been both effective and stimulated by the scan alone rather than by the results of clinical examination is therefore just three—two with meningioma and one with arteriovenous malformation.