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LETTER TO THE EDITOR

Extolling "palliative radiology" in the frail and elderly: each drop makes an ocean!: *Author reply*

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(The Editors do not hold themselves responsible for opinions expressed by correspondents)

To the Editor,

We would like to thank Dr Arora¹ for emphasising some of the issues we raised in our article "Pitfalls in imaging the frail elderly".² It is humbling to receive this positive response; ensuring appropriateness of investigation of frail and elderly patients is truly a global endeavour.

On the point of published guidance, the UK Royal College of Radiologists have long produced evidence-based guidelines, now in its 7th edition. This is available online (<http://www.irefer.org.uk/>), in print or as an app for mobile devices. However, the topic of imaging the frail elderly is not specifically covered in this publication.

We particularly applaud the author's reinforcement of the onus on radiologists to promote awareness of the consequences of radiological studies in this group of patients. In part, the "Choosing Wisely" campaign in the USA puts this into practice but is not particularly aimed at the frail elderly. While the healthcare model in the USA does differ somewhat from that in the UK, the development of short lists of evidence-based recommendations has inspired us to develop a list of our own. We present a list of five recommendations aimed at clinicians requesting radiological investigations in frail elderly patients:

(1) Prognostication is rarely an indication at the end of life. Although clinicians acknowledge that patients are

probably dying (and hence curative therapy is highly unlikely), scans are asked for "prognostic purposes". This is rather weak; scans rarely add anything in these circumstances and merely cause patients discomfort.

- (2) Older frail people do not like scans. The older and frailer they are, the less they like them. The more detailed and lengthy the scan, the less they like them. Whilst concerns about radiation dose are less important in this age group, consider the harm, inconvenience and distress caused simply by being sent for a scan.
- (3) Do not scan instead of talking. When faced with difficult clinical discussions with patients, their families and carers, it is tempting to avoid these by simply doing more tests. Resist this; it rarely helps and can increase distress.
- (4) Minimize the number of investigations where possible. For example, an elderly patient who is losing weight and in general decline may have sequential tests starting with radiographs, ultrasound, endoscopy and so on. These often gradually increase in complexity, invasiveness and expense. A single test, such as a contrast-enhanced CT of the chest, abdomen and pelvis is often all that is required.
- (5) If in doubt, discuss it with a radiologist. Clinical discussion is most indicated where there is clinical doubt, complexity and severity of symptoms. Best of all, it is free, readily available and has no side effects for the patient.

REFERENCES

1. Arora A. Extolling "Palliative Radiology" in the frail and elderly: each drop makes an ocean. *Br J Radiol* 2015; **88**: 20150011. doi: [10.1259/bjr.20150011](https://doi.org/10.1259/bjr.20150011)
2. Fawcett R, McCoubrie P. Pitfalls in imaging the frail elderly. *Br J Radiol* 2015; **88**: 20140699. doi: [10.1259/bjr.20140699](https://doi.org/10.1259/bjr.20140699)