

Mental Capacity Act: a must for all

Sir,

The Mental Capacity Act 2005 (Department for Constitutional Affairs, 2007) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. It states that it is good practice for professionals to carry out a proper assessment of a person's capacity to make particular decisions and to record the findings in the relevant professional records. A person is unable to make a decision for him-/herself if he/she is unable to understand, retain, use or weigh that information and to communicate his/her decision.

The authors conducted a retrospective audit of 40 patients from an adult and

older persons inpatient psychiatric unit for the months following implementation of the Mental Capacity Act (October to December 2007), to determine whether doctors are documenting capacity to consent to psychotropic medication. They found that, of the 40 patients, 23 had a change or initiation of medication and the rest of the patients continued on the medications they came in with. There were three comments that the medication was discussed and one comment about capacity. However, there was no documentation that the four components of capacity were tested in any of the 40 patients. Furthermore, there were no entries onto the trust mental capacity assessment form.

The recommendations from this audit include increasing awareness about capacity assessment among junior doctors by including it in the online induction pro-

gramme and making the assessment form (available on the Trust website) more user-friendly. It is also recommended that the capacity assessment for consent to psychotropic medication should be performed on the first ward round or within 1 week of admission.

Mental capacity assessment is not limited to psychiatry but applies across specialties which bear medicolegal significance, thus warranting training for all doctors.

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Diffuse bowel lesions: a possible cause of diffuse abdominal pain

Sir,

A 17-year-old boy presented to the accident and emergency department with a 24-hour history of diffuse abdominal pain. He denied any change in bowel or bladder habits. His only past medical history was acute leukaemia when he was 4 years old, which subsided completely after chemotherapy.

On examination, he appeared well, uncomfortable with normal vital signs. His abdomen was slightly tender in the right iliac fossa without guarding or rigidity. Both testes appeared small. His blood tests showed a white cell count of 13 000/ μ l blood with neutrophilia. A diagnostic laparoscopy showed diffuse serosal lesions

involving both the large and small intestine (Figures 1 and 2). The bowel lesions are vascular telangiectasia.

Telangiectasia is a dilatation of cutaneous or mucosal blood vessels which can be primary or secondary. Arterioles, venules and capillaries are affected. Telangiectasia in this patient is radiation induced. The causes of telangiectasia may be hereditary, organ failures, cirrhosis liver with portal hypertension (Higaki et al, 2008), venous hypertension of lower limbs, autoimmune conditions such as scleroderma, hyperoestrogenism and Turner's syndrome.

They can affect any part of the gastrointestinal tract (Polese et al, 2008) but are more common in the small bowel and may regress with age. The patient may present with anaemia (van Tuyl et al, 2007). Often the treatment is conservative and occasionally it may require bowel resection (Everett, 1967). This patient's appendix was found

to be inflamed and was thus removed. The telangiectasia was an incidental diagnosis and therefore left alone.

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Everett HH (1967) Hemorrhagic telangiectasia.

Report of a case necessitating extensive subtotal resection of the small intestine. *Am Surg* **33**: 59–63

Higaki N, Matsui H, Imaoka H et al (2008)

Characteristic endoscopic features of portal hypertensive enteropathy. *J Gastroenterol* **43**: 327–31

Polese L, D'Inca R, Angriman I et al (2008)

Gastrointestinal telangiectasia: a study by EGD, colonoscopy, and capsule endoscopy in 75 patients. *Endoscopy* **40**: 23–9

van Tuyl SA, Letteboer TG, Rogge-Wolf C, Kuipers

EJ, Snijder RJ, Westermann CJ, Stolk MF (2007)

Assessment of intestinal vascular malformations in patients with hereditary hemorrhagic telangiectasia and anemia. *Eur J Gastroenterol Hepatol* **19**: 153–8

Figure 1. Diffuse telangiectasia of the intestines.



Figure 2. Diffuse telangiectasia of the caecum.

