The abbreviated patient-held record: bridging the communication gap

Sir,

Lack of continuity in patient care continues to be one of the barriers to good patient care, and this is frequently attributable to poor communication between health-care professionals. Poor communication between secondary care and primary care may be a specific example, sometimes more glaringly highlighted in the newspapers (Sengupta, 2007; Hai, 2012) than in medical journals, arguably because that is perceived to be the best way to make health-care professionals 'sit up and take notice'.

One strategy to improve interdisciplinary communication would be to provide patients with a copy of the letter issued to the GP after each encounter with the health-care team. A fundamental specification for the format of each and every example of such an abbreviated health record would be the inclusion of an updated problem list and an updated drug list (Jolobe, 2002), the latter enumerating prescribed as well as over the counter drugs currently taken by the patient.

In the event of a medical emergency the patient would present the latest correspondence to the medical team in attendance, thereby making it possible for them to make a more informed diagnosis and also to devise a management strategy less fraught with risk.

Oscar Jolobe
Retired Geriatrician
c/o John Rylands University Library
Manchester M13 9PP

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Jolobe O (2002) Quality of referral letters. *Lancet* **360**: 1336
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Testosterone-induced erythrocytosis affecting haematocrit prediction of fluid responsiveness

Sir,

The authors wish to report an interesting finding in a young man who was admitted to the burns intensive care unit with 35% flame burns and inhalational injury following a blast injury. He had no significant medical problems. His initial blood gas on admission revealed a haemoglobin level of 17.5 g/dl and a haematocrit of 49.9%. Parkland's formula was used as a guide for fluid resuscitation along with goal-directed therapy using oesophageal Doppler monitoring to guide fluid responsiveness.

His repeat blood tests 8 hours after admission, during the fluid resuscitation, showed a haemoglobin level of 20.0 g/dl and haematocrit of 60%. Further tests revealed a persistently high haemoglobin and high haematocrit despite achieving optimal volaemic status as assessed by other haemodynamic monitors. He was successfully managed and ready for discharge after a week.

A detailed drug history obtained from the patient subsequently revealed that he had received a 9-week course of testosterone injection 8 months before admission. Testosterone regulates erythropoiesis and causes excessive erythrocytosis which leads to an increase in haemoglobin and haematocrit (Coviello et al, 2008). Although the mechanism by which testosterone stimulates erythropoiesis is poorly understood it has been suggested that it stimulates erythropoietin secretion and directly stimulates progenitor cells (Bachman et al, 2010).

The persistently high haemoglobin level and haematocrit despite large volumes of fluid administration caused a confusing picture given that the authors were not aware of the previous history of testosterone injections. If used as a marker for fluid responsiveness in this patient haematocrit would have been misleading and led to excessive fluid administration. It is important to obtain a history of testosterone injections particularly in young male patients presenting with polycythaemia and a raised haematocrit.

F Alagarsamy/G Khanna/B Emerson/ S Oakey
Specialist Registrar/Specialist Registrar/ Consultant Anaesthetist/Consultant Anaesthetist
Broomfield Hospital
Chelmsford
Essex CM1 7ET

Correspondence to: Dr F Alagarsamy (familaravi@yahoo.com)

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Coviello AD, Kaplan B, Lakshman KM, Chen T, Singh AB, Bhasin S (2008) Effects of graded doses of testosterone on erythropoiesis in healthy young and older men. *J Clin Endocrinol Metab* **93**(3): 914–19