IgG4-related disease as the differential diagnosis of hypophysitis

Sir,

In the reported case of granulomatosis with polyangiitis presenting as a pituitary lesion (vol 78(4), 2017, p. 234; https://doi.org/10.12968/hmed.2017.78.4.234) a plausible alternative diagnosis was hypophysitis attributable to immunoglobulin G4-related disease (Bando et al, 2014). The coexistence of polyarthritis and positive tests for cANCA-PR3 does not militate against immunoglobulin G4-related disease, given the fact that histologically proven immunoglobulin G4-related disease may sometimes be characterized by polyarthritis (Umekita et al, 2012). Even cANCA-PR3 positivity may be a feature of immunoglobulin G4-related disease (Della-Torre et al, 2016).

In one study, among 170 consecutive outpatients with hypopituitarism and/or central diabetes insipidus, 32 were identified who complied with criteria for suggesting IgG4-related hypophysitis. These patients included three with pituitary biopsy specimens characterized by stigmata of immunoglobulin G4-related disease such as storiform fibrosis, and infiltration by numerous IgG4-positive plasma cells (Bando et al, 2014).

Various magnetic resonance imaging stigmata have been reported in IgG4-related hypophysitis (Bando et al, 2014), including irregular peripheral contrast enhancement (Sosa et al, 2014), the latter similar to that documented in the recently reported case of hypophysitis. A favourable response to corticosteroids may also occur (Bando et al, 2014), as in the reported case.

Oscar MP Jolobe
Retired Geriatrician
Manchester Medical Society
Manchester M13 9PL
(oscarjolobe@yahoo.co.uk)

Bando H, Iguchi G, Fukuoka H et al (2014) The prevalence of IgG4-related hypophysitis in 170 consecutive patients with hypopituitarism and/or central diabetes insipidus and review of the literature. *Eur J Endocrinol* **170**(2): 161–172. https://doi.org/10.1530/EJE-13-0642

Della-Torre E, Lanzillotta M, Campochiaro C et al (2016) Antineutrophil cytoplasmic antibody positivity in IgG4-related disease. *Medicine* **95**(34): e4633. https://doi.org/10.1097/MD.0000000000004633

Sosa GA, Bell S, Christiansen SB et al (2014) Histologically confirmed isolated IgG4-Related hypophysitis: two case reports in young women *Endocrinol Diabetes Metab Case Rep* **2014**: 140062. https://doi.org/10.1530/EDM-14-0062

Umekita K, Kaneko Y, Yorita K et al (2012) Arthropathy with infiltrate IgG4-positive plasma cells in synovium. *Rheumatology* **51**(3): 580–582. https://doi.org/10.1093/rheumatology/ker350

Documentation standards and clinical coding

Sir,

We commend the article by Parwaiz et al (vol. 78(2), 2017, p104; https://doi.org/10.12968/hmed.2017.78.2.104). The authors raise important points regarding the need for clinical information to be of high specificity, volume and relevance. One noteworthy omission from the article was the use of medical documentation for clinical coding. Coding is crucially the gateway to inpatient remuneration in the UK.

Documentation standards should be as few as possible to account for different clinical contexts and local demands (Royal College of Physicians, 2008). This is particularly relevant for time-pressured records such as discharge letters.

Inspired by this article, the authors established a coding-focussed minimum standard for discharge letters where completion of both the presenting complaint and clinical summary sections was mandatory. It was hypothesized that coding time would decrease with adherence to this standard.

A pre-intervention study of 207 admissions to a paediatric plastic surgery service, over 4 months (01/01/2017–30/04/2017), showed that the standard was breached, on average, in 66.2% of cases (minimum 40.3%, maximum 89.7%). Over a subsequent 4-week period (15/05/2017–12/06/2017) the following interventions were implemented:

1. Education (presentations, emails and leaflets)
2. Designating a clinician to amend letters in breach on a weekly basis.

Coding times were measured pre- and post-intervention.

Of 34 admissions within the intervention period, education reduced the number of letters in breach by four (23.5%) and a clinician rectifying the letters by 10 (58.8%). The final breach rate was three (8.8%). Time taken for a coder to locate a diagnosis or reason for admission decreased by an average of 34 seconds per admission (minimum 0 s, maximum 123 s).

Establishing a minimum standard for discharge letters improves the speed of coding. Such time-saving exercises are significant when extrapolated across the breadth of inpatient activity within a setting. Accrued time could be used to assess and improve coding pathways. Providing education and performing regular reviews of discharge letters is crucial for upholding the veracity of coding data.

Luke Roberts
Clinical Coding Improvement Manager
Evelina London Children's Hospital
St Thomas's Hospital
London SE1 7EH
(luke.roberts@gstt.nhs.uk)
Samuel Alner
Service Improvement Team Project Coordinator
Evelina London Children's Hospital
St Thomas's Hospital
London

Royal College of Physicians (2008) A Clinicians Guide to Record Standards - Part 2: Standards for structure and content of medical records and communications when patients are admitted to hospital. www.rcoa.ac.uk/sites/default/files/FPM-clinicians-guide2.pdf (accessed 19 July 2017)