Training to recognize trainees in difficulty

Sir

Professor Paice and Victor Orton (vol 65(4), 2004, p. 238) have candidly dealt with the issue of poorly performing trainees. The fact that many supervisors resort to writing negative reports or simply allow trainees with problems to pass on to other units highlights a need for training the existing and future educational supervisors (specialist registrars) in this area.

Poor performance is not restricted to trainee doctors alone and may be recognized in doctors in non-training career grade posts. Lack of career progression, feeling of being undervalued and boredom derived from being assigned mundane jobs can all contribute to deteriorating performance in this category of doctors.

A significant proportion of trainee doctors in the NHS hold overseas qualification and the majority of them are highly intelligent and competent. Dealing with overseas doctor in difficulty requires a special understanding of the additional difficulties faced by this group. Most overseas doctors struggle to find their first training post and many end up taking non-training posts. Those fortunate enough to land training jobs are constantly under pressure to renew their visa, every few months in some cases. Other factors that can increase stress levels are cultural differences and being away from their families. Induction programmes aimed at dealing with such issues can help them to perform to the best of their abilities.

Educational supervisors should have access to a more formal and structured training scheme designed to improve their skills in dealing with the trainee in difficulty.

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Resistant ascites: a high price to pay

Sir,

A 60-year-old woman was admitted to a district general hospital with a 6-month history of resistant ascites secondary to known alcoholic liver disease. She had consumed unquantified volumes of whisky until her divorce 6 years earlier and claimed to have been abstinent from alcohol since then. She had been receiving a prescription for spironolactone 100 mg twice daily and frusemide 40 mg twice daily following an inpatient admission for ascites 8 months previously. Recent imaging with ultrasound and computed tomography scans had shown a shrunken, homogenous liver with extensive ascites and reduced portal vein flow consistent with liver cirrhosis. The hepatic vein was patent.

During her admission the patient's ascites failed to respond to increasing doses of diuretics despite the exclusion of infection, co-existing liver disease and heart disease. A diagnosis of decompensated alcoholic liver disease was made.

On day sixty-three of the hospital admission, while the patient was being prepared for transfer to a specialist liver unit for further management, a member of the ward staff found a collection of approximately 300 diuretic tablets in her bedside locker. Three weeks after transfer she developed both hepatorenal syndrome and spontaneous bacterial peritonitis. She died soon afterwards following an electromechanical dissociation arrest.

The cost of the unused diuretics was perhaps only £130 in total. However, the approximate cost of this patient's hospital bed, food and nursing during her inpatient stay was £14 427, calculated at £229 per day. Excluding the cost of investigations that may not have been necessary had this patient taken and responded to diuretics as she had done in the past, the cost to the NHS of her non-compliance was around £14 557. The cost to the patient was immeasurably greater, highlighting both the medical and financial implications of non-compliance with treatment.

Resistant ascites is defined as:

> **'that which cannot be mobilised or the early recurrence of which cannot be satisfactorily prevented by medical therapy' (Arroyo et al, 1989).**

The more conventional differential diagnosis is intra-abdominal malignancy, massive hepatic metastases, nephrogenic ascites in end-stage renal failure and Budd–Chiari syndrome. These diagnoses were ruled out by investigation.

The management of resistant ascites in alcoholic liver disease is often unrewarding. This case demonstrates non-compliance with medical therapy as a rare but potentially expensive cause of intractable ascites in alcoholic liver disease that may have cost the patient her life and which needs to be considered in the management of such patients. Non-compliance must be considered as a differential diagnosis of 'failure to respond to medication'.

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Arroyo V, Epstein M, Gallus G, Gentilini P, Ring-Larsen H, Salerno F (1989) Refractory ascites in cirrhosis: mechanism and management. *Gastroenterol Int* **2:** 195–207