

Correspondence Section

References

1. O Kemp, AM Lockwood, GL Lockwood et al. The impact of education on the knowledge and documentation of Driver and Vehicle Licensing Agency (DVLA) driving restrictions by doctors. *Acute Medicine* 2011; **10(1)**: 13-17
2. DVLA Drivers Group. For Medical practitioners- At a Glance Guide to the current Medical Standards of fitness to drive. February 2011 p6.
3. General Medical Council. GMC supplementary guidance. Confidentiality: reporting concerns about patients to the DVLA or DVA. September 2009. p1, Para. 4 & 5.
4. http://www.dft.gov.uk/dvla/medical/medical_advisory_information/reviewofdm.aspx

Authors' response

We are grateful to Dr Hill for his interest in our article; in response to his concern regarding the role of the doctor in advising the patient their fitness to drive, we have sought further clarification from the DVLA. Dr Judith Morgan, senior medical advisor to the DVLA has provided us with the following statement which readers may find of use in their discussions with patients.

"We are all in agreement that the doctors' role does extend to informing their patients when they have a medical condition which may affect their ability to drive and to advise them that they should notify the DVLA of any such condition. The Secretary of State (in practice the DVLA), is unable to make a licensing decision until all the available relevant medical information has been considered. It may therefore be a relatively lengthy process to obtain all necessary reports and, during this period, the licence holder normally retains legal entitlement to drive under Section 88 of the Road Traffic Act 1988. However, by reference to the 'At a Glance Guide to the Current Medical Standards for Fitness to Drive', the doctor in charge of their care should be able to advise the driver whether or not it is appropriate for them to continue to drive during this period. Patients may be reminded that if they choose to ignore medical advice to cease driving, there could be consequences with respect to their insurance cover. Doctors are advised to document formally and clearly in the notes the advice that has been given.

I fully appreciate the authors' views that the doctor can help their patients to plan for the future if they are able to give an idea as to how long a period off driving is likely to be. Such advice should be given after considering the diagnosis against the advice in the current edition of the 'At a Glance' guide. A caveat would be that it is advice only and the definite decision will not be made until the DVLA has considered all available information."

We hope this provides the necessary clarification which Dr Hill was seeking.

Drs Gabrielle and Alistair Lockwood

Outpatient parenteral antibiotic therapy for cellulitis

Dr Phil Jacobs

Consultant Acute Physician

Barnet Hospital, Wellhouse Lane, Barnet, Hertfordshire, EN5 3DJ

Dr Reg Coleman

Consultant Acute Physician

Barnet Hospital, Wellhouse Lane, Barnet, Hertfordshire, EN5 3DJ

We read with interest the review of the OPAT service in Birmingham, featured in the most recent issue of *Acute Medicine*.¹ Could the authors confirm the percentages of patients deemed suitable for outpatient therapy with the various conditions compared to the totals presenting to their organisation? The NHS Institute for Innovation and Improvement's Directory of Ambulatory Emergency Care for Adults² recommends figures of 60-90% for both cellulitis and gastroenteritis, and 30-60% for UTIs. We are currently piloting a cellulitis OPAT service and aim to save many hundreds of bed days per annum.

References

1. Yin May Yan, et al; Delivering Outpatient Antibiotic Therapy (OPAT) in an Acute Medical Unit. *Acute Medicine* 2011; **10(1)**: 22-25
2. Directory of Ambulatory Emergency Care for Adults. Institute for Innovation and Improvement March 2010 ISBN 978-1-907045-79-0

Authors' response

Cellulitis is the 5th most common presentation to hospital in our unit. The CREST guidelines¹ classify patients with respect to the severity of their cellulitis. Class 1 patient are usually managed in the community with oral medication. Class II patients that have signs of systemic upset or those who are systemically well but with a co-morbidity such as peripheral vascular disease, obesity etc that may compromise their recovery are the group of patients that may require intravenous antibiotics that can be supplied using an OPAT service. Class III and IV usually require initial hospital admission, though their length of stay can be shortened with the use of an OPAT type service. The number of patients that can be effectively treated depends on the approach used. The NHS Institute for Innovation and Improvement's Directory of Ambulatory Emergency Care for Adults² suggest that 60-90% of patients with cellulitis could potentially be treated in the community. Using a clinic based approach requires a patient to be mobile and well enough to attend hospital on a daily basis. This has been predominantly the method we adopted leading to a 30-40% reduction in hospital admissions for patient with cellulitis over the course of a year. With an out-reach district nurse type approach the numbers increase as patients can be treated in their homes. However this requires the patient to have a good social network to ensure other activities of daily living are catered for.

Reference

1. <http://www.gain-ni.org/Library/Guidelines/cellulitis-guide.pdf> June 2005

Nigel Langford

City Hospital, Dudley Road, Birmingham B18 7QH;

Email: nigel.langford@swbh.nhs.uk