[0.22-3.49]) rather than the HR (0.93, 95% CI [0.20-4.25]) had been used from Kamiza et al., which included HBV/HCV co-infected patients. Whereas, in HBV mono-infected patients, the risk of MM was actually 1.04 (95% CI 0.22-4.90).5 An et al mentioned the Li et al meta-analysis,6 with an OR of 1.3 (95% CI: 0.92-1.82, P = 0.14) for the risk of MM. This result became statistically significant in the sub-analyses when evaluating high-quality studies, and those with hospital-based controls (OR: 1.44-1.63, all P < 0.01), which was consistent with our main findings.

In summary, our study suggested a positive association between CHB and increased risk of MM, and more large-scale prospective studies are needed to validate our findings.

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The author’s declarations of personal and financial interests are unchanged from those in the original article.2

LINKED CONTENT
This article is linked to Su et al and An papers. To view these articles, visit https://doi.org/10.1111/apt.15132 and https://doi.org/10.1111/apt.15590.

REFERENCES

DOI: 10.1111/apt.15605

Letter: the Shock Index and predicting outcomes in patients with upper gastrointestinal bleeding

EDITORS,
We are pleased that Saffouri et al have amended their reporting of the findings of the 2015 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report ‘Time to Get Control’ into severe gastrointestinal (GI) bleeding1 from their initial online version of the paper.2

NCEPOD reports do not attempt to make academic assessments of the relative merits of different management options. Rather they represent a snapshot peer review of real-world care organisation and delivery in the NHS and their recommendations reflect this. The NCEPOD report into GI bleeding made no attempt to recommend one risk stratification tool over another.

A clear finding of the NCEPOD report was that existing scoring tools are poorly utilised (or at least recorded). In patients undergoing upper endoscopy, a pre-endoscopy risk assessment score was recorded in only 34% (125/367).1 Even when tools were used they were often wrongly calculated. The low compliance with the recommended dedicated risk scores for upper GI bleeding combined with the absence of a validated risk scoring system for lower GI bleeding at the time of data collection (2013) prevented their use in the NCEPOD study.

As an objective means of assessing the haemodynamic impact of the presenting bleed, the NCEPOD authors calculated the shock index retrospectively at the time of presentation with the GI bleed. In the NCEPOD report, 64% (377/587) of patients had a shock index
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>0.7 and 26% (152/587) >1 at the time of presentation with their GI bleed. This is a very different patient cohort from that of Saffouri et al. As shock index is a simple calculation of systolic blood pressure/heart rate, it is perhaps predictable that it will perform more poorly than scoring systems which include heart rate and systolic blood pressure as components (Glasgow-Blatchford and Rockall scores). AIMS65 includes systolic blood pressure alone.

In the paper by Saffouri et al 45.5% of patients (1368/3012) had an endoscopically confirmed upper GI bleed. The remainder had a normal endoscopy (297), no endoscopy (937) or are unaccounted for in the paper (410).

The NCEPOD report made 26 recommendations to improve the care of patients with GI bleeding. These included a recommendation to encourage the development of risk stratification tools relevant to all GI bleeding presentations and sites of bleeding as clinical presentations do not reliably predict the site or type of bleeding. Embedding any risk assessment tools in care pathways is essential. A scoring system applicable to all GI bleeds at presentation may be better adopted.

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REFERENCES


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Letter: the Shock Index and predicting outcomes in patients with upper gastrointestinal bleeding. Author’s reply

EDITORS,

We thank Drs. McPherson and Hammond for their interest in our paper and their helpful comments. We agree that existing risk scores are poorly utilised in clinical practice, which may relate to the relative complexity of some existing scores, uncertainty regarding their role in ‘real-world’ clinical practice, and difficulty in identifying higher-risk patients who may require specific management. The NCEPOD report used the Shock Index as a marker of gastrointestinal (GI) bleeding severity and found it to be associated with mortality. This led us to explore the use of the easily calculated Shock Index as a predictor of clinically relevant endpoints in unselected patients presenting with upper GI bleeding.

We agree that several existing risk scores include some haemodynamic parameters. However, since there are very limited published data on use of the Shock Index in GI bleeding, we were very keen to assess its role in predicting outcomes in our large international and consecutive upper GI bleeding cohort. This was a real-world, unselected cohort, which therefore included patients who had a normal endoscopy and others who never had endoscopy.

The last UK national audit of upper GI bleeding found that 26% of patients notified to gastroenterologists with this condition did not have inpatient endoscopy.3

Finally, we agree that the development of a relatively simple risk score that accurately predicts clinical endpoints in both upper and lower GI bleeding would be of major benefit to clinicians. To that end, we are undertaking further work on the ‘ABC’ score (Age, Bleeding, Comorbidities; also known as the international bleeding risk score) mentioned in our article, which shows promise in this regard.4,5

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LINKED CONTENT

This article is linked to Saffouri et al and McPherson and Hammond papers. To view these articles, visit https://doi.org/10.1111/apt.15541 and https://doi.org/10.1111/apt.15605.

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