education

FROM THE JOURNALS Edited highlights of weekly research reviews on https://bit.ly/2PLtil8

Attitudes of over 65s to deprescribing

Many clinicians observe some patients who resist deprescribing and this may be discouraging them from deprescribing for other patients to avoid conflict. That is why this paper on the attitudes of older Americans is so important. It shows that most would be willing to have medication deprescribed if their physician said it was possible, and that more than two thirds want to reduce the number of medicines they are taking. I sincerely hope this research encourages open discussion between clinicians and their patients to reach a decision that is patient centred.

JAMA Intern Med doi:10.1001/jamainternmed.2018.4720

Researchers' inappropriate requests for data analysis

Have you been mis-sold study data by researchers? Even if you critically analysed it, you were likely mis-sold it. You could be entitled to your money back if your claim involves falsifying statistical significance to support a desired result. If you think you were mis-sold study data, act now and we'll interpret your claim on the basis of expectation, not actual results. Start your claim now you can find out for free if the power calculation was really a priori or post hoc. Don't miss the claim deadline or we'll ignore key missing data that could bias the results.

Wang et al's survey of 400 statisticians provides worrying insight into the mis-selling scandal in research today and is a must read. The statisticians weren't asked what they did with the inappropriate requests but a glance at the state of research reporting might help you extrapolate.

Ann Intern Med doi:10.7326/M18-1230

Safety of beta blockers in pregnancy

It is a truth universally acknowledged that pregnancy makes treatment of any medical condition anxiety inducing for patient and clinician alike. Isn't it lucky then, that this paper is about beta blockers? I jest—beta blockers are not how I would start to treat anxiety, and the reason for treatment in this large cohort study was actually hypertension.

So, to the point, Bateman et al focus on beta blocker use in the first trimester in pregnant women with a diagnosis of hypertension in Denmark, Finland, Iceland, Norway, Sweden, and the US. They assessed the risk of congenital malformations and concluded that there was no "large increase in the risk for overall malformations or cardiac malformations, independent of measured confounders."

There will always be a long list of confounders for this type of study design. But, in practice, decisions must be made, and this is the best available evidence at the moment.

Ann Intern Med doi:10.7326/M18-0338

The Roux-en-Y reassessment: which measure of weight regain is useful?

Look to this study, not for how it will affect you or your practice (it won't unless you are a patient or researcher of bariatric surgery), but to admire the authors' concern for which outcome of weight regain after bariatric surgery is associated with outcomes that are important for patients. King et al conclude that their findings "may inform standardising the measurement of weight regain in studies of bariatric surgery"—a laudable aim given how many different ways of measuring weight regain there are.

There's weight, body mass index (BMI), weight regain as a percentage of pre-surgery weight, weight regain as a percentage of nadir weight, and thresholds of these such as greater than 10 kg, greater than 5 BMI points, 10% of pre-surgery weight, and so on. This study compared 13 measures of weight regain for association with progression of diabetes, hyperlipidaemia, and hypertension, and declines in quality of life (related to physical and mental health) and satisfaction with surgery. Weight regain quantified as percentage of maximum weight lost came out top. This may disappoint some readers as it requires more than one step of calculation.

JAMA doi:10.1001/jama.2018.14433

Clindamycin for bacterial vaginosis in pregnancy

The French government funded PREMEVA trial is a breath of fresh air. This large double blind randomised controlled trial found no evidence of reduced risk of late miscarriage or spontaneous very preterm birth with screening for and subsequent treatment of bacterial vaginosis. The treatment was clindamycin, and those who received it had more diarrhoea and abdominal pain than those randomised to placebo. Cancelling out an indication for antibiotics—great. Filtering this into clinical practice—priceless.

Lancet doi:10.1016/S0140-6736(18)31617-9

Alex Nowbar is a clinical research fellow at Imperial College London

PRACTICE POINTER

Acute upper gastrointestinal bleeding

Emma Sverdén,[1 2] Sheraz R Markar,[1 3] Lars Agreus,[4 5] Jesper Lagergren[1 6]

[1]Upper Gastrointestinal Surgery, Department of Molecular Medicine and Surgery, Karolinska Institutet, Karolinska University Hospital, Stockholm, Sweden
[2]Department of Upper Gastrointestinal Surgery, South Hospital, Stockholm
[3]Department of Surgery and Cancer, Imperial College, London
[4]Division of Family Medicine and Primary Care, Department of Neurobiology, Care Sciences, and Society, Karolinska Institutet
[5]University of Newcastle, Australia
[6]School of Cancer and Pharmaceutical Sciences, King's College London, and Guy's and St Thomas' NHS Foundation Trust

Correspondence to: E Sverden emma.s.eklund@gmail.com

LEARNING MODULE

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CPD READING

0.5 HOURS

Bleeding from the upper gastrointestinal tract (oesophagus, stomach, and duodenum) occurs in approximately 100 per 100 000 people annually.[1 2] It is a medical emergency associated with substantial mortality. A UK audit in 2007 found an overall mortality of 10%.[3] This practice pointer provides a guide to the initial management of upper gastrointestinal bleeding and subsequent management of bleeding that results from peptic ulceration, the most common cause.[6]

HOW PATIENTS WERE INVOLVED IN THE CREATION OF THIS ARTICLE

We asked patients who were hospitalised for peptic ulcer bleeding about their experience and for comments. Their experience of discomfort caused by a nasogastric tube was often mentioned. We included this in the article, stressing current guidance that nasogastric tube is not usually clinically necessary.

WHAT YOU NEED TO KNOW

- Acute upper gastrointestinal bleeding is a medical emergency, and appropriate initial resuscitation is crucial
- A normal haemoglobin value and blood pressure at presentation do not rule out substantial bleeding—increased heart rate is a more reliable measure of substantial blood loss
- The Glasgow-Blatchford score can help identify patients for whom outpatient care is suitable
- Aim for a haemoglobin level of 70-90 g/L for those without cardiac problems

How might you manage patients initially?

Assessment and resuscitation

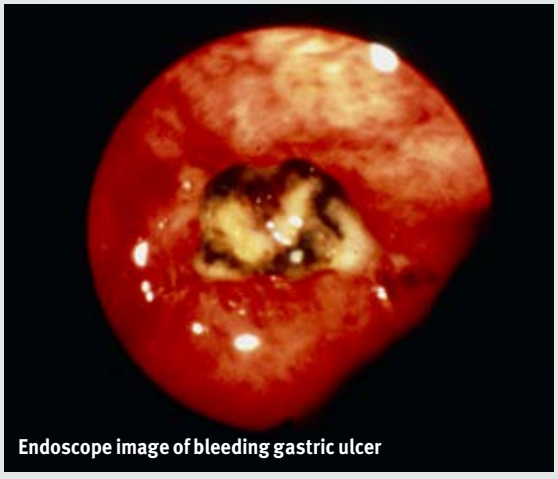
Patients may present with melaena, vomiting fresh blood, or with "coffee ground" vomiting. Abdominal pain may also be present. Fresh per rectal bleeding (haematochezia) can occur in major brisk bleeding.[7]

Assess the patient's haemodynamic status. Look for visible signs of bleeding. Begin resuscitation in parallel with further clinical assessment. An approach to the initial management of patients with upper gastrointestinal bleeding is shown in the infographic (p 160). Early assessment by the intensive care team is recommended in the unstable patient, or where there is airway compromise (such as from haematemesis) or reduced level of consciousness.[2] Obtain a medical history alongside a physical examination. Monitor physiological observations including heart rate, blood pressure, respiratory rate, oxygen saturation, and level of consciousness. Large bore peripheral venous access is required, with at least two 16-18 gauge intravenous cannulas recommended.[2] Crystalloids are recommended for volume replacement.[8]

Blood tests should include haemoglobin level, haematocrit, platelet count, prothrombin time, international normalised ratio (INR), urea, creatinine, electrolytes, liver function, and blood cross-matching. When bleeding is acute, haemoglobin may be unchanged, even if the patient is haemodynamically unstable.[9] This is because the patient loses blood cells and also plasma. But within a few hours, interstitial fluid moves into the vascular space, and the

Causes of upper gastrointestinal bleeding[4 5]

- Peptic ulcer (31%-67%)
- Gastritis or duodenitis (7%-31%)
- Variceal bleeding (4%-20%)
- Erosive oesophagitis (3%-12%)
- Mallory-Weiss tear (4%-8%)
- Tumours (2%-8%)
- Aorto-enteric fistulas, arteriovenous malformations or Dieulafoy's lesions (2%-8%)



Endoscope image of bleeding gastric ulcer

haemoglobin level falls. Reassessing haemoglobin within a few hours can be clinically useful. Similarly, blood pressure may be normal, particularly in healthy individuals, because of compensatory vasoconstriction, increased cardiac contractility, and tachycardia. A normal haemoglobin value and blood pressure in the acute setting does not exclude life threatening bleeding. An increased heart rate is a more sensitive early objective measure of haemodynamic status.[10]

In patients with anaemia, evidence from randomised trials and observational studies supports a restrictive blood transfusion strategy with a target haemoglobin level of 70-90 g/L.[8-12] This is to avoid counteracting the body's own haemostatic mechanisms of hypotension, vasoconstriction, and thrombus formation. For patients with ischaemic heart disease, aim for the higher haemoglobin level within this range to prevent myocardial infarction.[13 14]

Routine nasogastric tube placement is uncomfortable for patients and is no longer recommended. Previously it was thought to help distinguish between upper and lower gastrointestinal bleeding or obtain better visibility at endoscopy.[15] If emergency endoscopy is performed without fasting or if the stomach might contain much blood, a nasogastric tube is recommended.[16]

Pre-endoscopy scoring systems are useful for risk stratification. The Glasgow-Blatchford Score is especially useful to identify patients at low risk of extensive continued bleeding, who may be managed in the outpatient setting.[12]

Pharmacological treatment

Proton pump inhibitors

Intravenous high dose proton pump inhibitor, given as a bolus (eg, omeprazole 80 mg) followed by continuous infusion (eg, omeprazole 8 mg/hour), is recommended by the European Society of Gastrointestinal Endoscopy for patients who require admission.[12] For patients with ongoing bleeding or a visible vessel at endoscopy, the infusion can be continued for 72 hours. Although proton pump inhibitor treatment reduces bleeding stigmata and the need for endoscopic haemostatic intervention, a systematic review found no evidence that it reduces re-bleeding rates or mortality.[17] A systematic review of continuous intravenous versus intermittent oral proton pump inhibitor therapy for high risk bleeding ulcers found both approaches to be equally effective, so the use of continuous proton pump inhibitor infusion is controversial.[18] This specific component of the treatment may be tailored for each patient.

Prokinetics

A single dose of intravenous erythromycin (250 mg) given 30 to 120 minutes before endoscopy is generally recommended to promote gastric emptying and improve endoscopic visualisation.[2-19]

Suspected variceal bleeding

If variceal bleeding is suspected (for example, in patients with liver disease or alcohol abuse) administer a splanchnic vasoconstrictor, such as terlipressin or octreotide, intravenously. This is typically given with a broad spectrum antibiotic such as a quinolone, cephalosporin, or piperacillin-tazobactam, because of the high risk of severe bacterial infections in these high risk patients.[20]

thebmj Visual summary

Management of upper gastrointestinal bleeding

This visual summary presents a practical approach to initial management of patients with upper gastrointestinal bleeding. Peptic ulcers are the most common cause of serious bleeding from the oesophagus, stomach, and duodenum, and can be identified with simple diagnostic tests

Initial assessment

Check circulatory status to assess need for immediate interventions

Haemodynamically stable

Signs of current bleeding

- Hematochezia
- Haematemesis

Blood pressure may remain normal initially, so increased heart rate is a more sensitive measure of circulatory status

Urgent intensive care involvement required for:

- Haemodynamically unstable
- Airway compromise
- Hypoxia
- Reduced level of consciousness

Actions in parallel

Obtain blood chemistry

Obtain medical history

Initial resuscitation

2 x large bore intravenous access

Urinary catheter (if required)

Intravenous fluids

Pharmacological treatment (proton pump inhibitor)

Risk stratification

Glasgow-Blatchford Score (GBS)

Systolic blood pressure mmHg	
100–109	1
90–99	2
< 90	3

Blood urea mmol/L	
6.5–7.9	2
8.0–9.9	3
10.0–24.9	4
≥ 25.0	6

Haemoglobin g/dL		
Men	Women	
12.0–12.9	10.0–11.9	1
10.0–11.9		3
< 10.0	< 10.0	6

Pulse ≥ 100	1
Melaena	1
Syncope	2
Hepatic disease	2
Cardiac failure	2

Total score

- 0 – 1: Low risk of death. Can be considered for outpatient management
- 5+: Increased risk of 30-day mortality
- 7+: Predicts need for endoscopic haemostatic intervention, but needs individual evaluation

Total score 0 – 1

Early discharge

Endoscopy in outpatient clinic

Total score 2+

Haemodynamically stable

Endoscopy within 24 hours

Proton pump inhibitor

Eradication of any *Helicobacter pylori* infection

Haemodynamically unstable

Emergency endoscopy

Successful haemostasis

Not successful haemostasis

Embolisation therapy

Transcatheter arterial embolisation should be considered as the next alternative after unsuccessful endoscopy, because it is effective and associated with less risk of major complications than surgery

Surgery

If transcatheter arterial embolisation is unsuccessful or not available, surgery is the only remaining treatment to stop peptic ulcer bleeding. A minimal surgical approach with over-sewing of the ulcer is preferable, but depending on size and location of ulcer, open surgery may be required

Coagulopathy

National Institute for Health and Care Excellence (NICE) recommendations for managing coagulopathy in upper gastrointestinal bleeding. This and other guidance on coagulopathy in critically ill patients is mostly based on expert guidance as direct evidence is limited.[12 21] No strong evidence exists to support the use of tranexamic acid.[34 35] Tranexamic acid increases the risk of cardiovascular and thromboembolic events, and many patients with upper gastrointestinal bleeding are already at increased risk of cardiovascular and thromboembolic events.[4]

Whenever severe gastrointestinal bleeding occurs in patients taking novel oral anticoagulants (NOACs), seek further advice from a haematology specialist in coagulation.[24 25] If the patient is haemodynamically unstable, expert consultation should not be given priority over endoscopic intervention to stop the bleeding.

Endoscopic intervention

The timing of endoscopic intervention is the subject of debate and requires clinical judgment.[26 27] Definitive endoscopic treatment should not be unduly delayed if the patient remains haemodynamically unstable despite adequate resuscitation measures.[28 29] However, where the patient is stable, or becomes so after resuscitation, the optimal timing of the initial endoscopy is debatable.[26 30] A recent large cohort study among stable patients with severe comorbidity showed an association between those who underwent endoscopy within 6-36 hours and reduced in-hospital mortality, compared with those who had endoscopy later.[26] Among patients who were haemodynamically unstable there was an association between those who underwent endoscopy within 6-24 hours and reduced in-hospital mortality, compared with patients undergoing endoscopy within 0-6 hours or after >24 hours.[26] The European Society of Gastrointestinal Endoscopy recommends endoscopy within 24 hours for haemodynamically stable patients, and within 12 hours for patients with haemodynamic instability that persists despite resuscitation.[12] Endotracheal intubation before endoscopy does not appear to influence in-hospital mortality or length of hospital stay in patients with upper gastrointestinal bleeding, but the published studies are few, small, and mostly of questionable methodological quality.[12 31 32] In the absence of more robust evidence, the decision whether to intubate or not must be individualised for each patient, accounting for haemodynamic instability, but also risk of aspiration and the need for airway protection.

Ninety percent of patients do not bleed again after endoscopic haemostatic intervention for a bleeding peptic ulcer.[33] Routine second look endoscopy is therefore not recommended unless the patient develops clinical signs of re-bleeding.[34] Gastric ulcers should be biopsied to exclude malignancy. Repeat endoscopy with biopsies in the outpatient clinic is indicated for gastric ulcers until they are completely healed, usually within 6-8 weeks.

EDUCATION INTO PRACTICE

- How does your work place identify low risk patients who can be managed in an out-patient setting?
- How many of your patients with peptic ulcer bleeding leave with clear written advice on the use of ulcer promoting drugs and proton pump inhibitors?

How to manage patients after the acute bleeding episode

Anti-acid medication and eradication of *Helicobacter pylori*

Where patients have bleeding ulcers associated with *Helicobacter pylori*, eradication therapy reduces the re-bleed rate from 20% to 3%.[38-40] All patients who have had a bleeding peptic ulcer should be tested for *H pylori* as soon as possible, preferably at the first endoscopy. Acute bleeding increases the risk of a false negative test, so if the initial test is negative the patient should be offered re-testing, preferably within a month.[39 40 42]

Duodenal ulcers associated with *H pylori* do not routinely require further proton pump inhibitor treatment outside the eradication period. For gastric ulcers associated with *H pylori*, proton pump inhibitor therapy should continue until the control endoscopy is performed, 6-8 weeks later.[46]

In peptic ulcers not associated with *H pylori* or non-steroidal anti-inflammatory drugs (NSAIDs), the risk of recurrent bleeding appears to be higher. An observational study showed that 42% of these patients had another bleeding episode within seven years.[45] This supports the use of long term maintenance therapy with a proton pump inhibitor in this group of patients. Explain to patients the close link between smoking and peptic ulcer disease.[46]

Discontinuation of antiplatelet and anti-inflammatory drugs

When to restart aspirin for secondary prevention of cardiovascular disease depends on the endoscopic findings. Aspirin can be continued the same day in patients with peptic ulcer bleeding defined as Forrest grade IIc (adherent clot) or III (flat haematin spot or clean base). Patients with Forrest grade Ia-IIb (spurting bleed or oozing bleed) can resume aspirin three days after endoscopic haemostasis has been achieved[12 49] in combination with continuous (life long) treatment with a proton pump inhibitor to prevent recurrent bleeding. Maintain a low prophylaxis dose, to minimise the risk of long term adverse effects (increased risk of hip fracture, *Clostridium difficile* infection, pneumonia, and possibly gastric cancer).[48]

Advise patients who use NSAIDs other than aspirin to avoid these if possible. If not feasible, changing to a cyclo-oxygenase-2 inhibitor can be as effective in avoiding recurrent peptic ulcer bleeding as combining a regular NSAID with a proton pump inhibitor.[49] In patients at higher risk of re-bleeding (eg, older patients or those with multiple comorbidities) combining a cyclo-oxygenase-2 inhibitor and a proton pump inhibitor is recommended.[50] Prescribing a proton pump inhibitor to people who take NSAIDs reduces the risk of new peptic ulcer bleeding by 50%-80%.[50] Histamine 2 receptor inhibitors (eg, ranitidine) have no advantage over proton pump inhibitors in terms of re-bleeding risk, but can be considered as an alternative for long term treatment.[51]

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CLINICAL UPDATES

The health needs of forced migrants

CPD READING
0.5 HOURS

Angela Burnett,[1] Tracy Ndovi

[1]Freedom from Torture, London
[2]Survivors Speak OUT, London
Correspondence to: A Burnett aburnett@freedomfromtorture.org

This article provides an overview of the healthcare needs of migrants who have been forced to leave their home countries. It aims to offer guidance to, and raise awareness among, health workers caring for them.

The "cultural bereavement of exile"[1] is the loss of social structures, cultural values, community rituals, relationships, and material features experienced by forced migrants. Meeting the healthcare needs of those affected can help achieve safety and rehabilitation.

"If you have never been tortured, been forced to make a dangerous journey, or leave your child, you may not fully understand what it does to a human being"—Tracy Ndovi

Migrants include asylum seekers, refugees, and people who have experienced torture, armed conflict, and human trafficking (for slavery or sexual exploitation). They are at risk of several physical and mental illnesses. Management often requires approaches that are different from those used for the rest of the population.

HOW PATIENTS WERE INVOLVED IN THE CREATION OF THIS ARTICLE

This article was co-written by Tracy Ndovi, an expert with lived experience of forced migration and who is a member of Survivors Speak OUT (SSO), a survivor-led activist network supported by Freedom from Torture. SSO provides a voice to people who have experienced torture and empowers them to support others and advocate for change.

WHAT YOU NEED TO KNOW

- Conflict, torture, trafficking, and environmental disasters are common reasons for forced migration
- When discussing health, consider using a trained interpreter to avoid placing responsibilities on friends, family, or children

- Purposeful activity can help tackle concerns about the past, a pending asylum case, and/or the future
- Distinguish mental illness from a natural emotional response to trauma
- Offer screening for sexually transmitted infection to people who have experienced sexual violence

What are the barriers to providing forced migrants with healthcare?

Entitlement rules may be complex.[4] People from countries where health services differ structurally may have varying expectations. For example, some may anticipate a hospital referral for a condition that is usually treated in primary care. Unproductive or missed appointments may occur because of memory and cognitive challenges, literacy and language problems, shame, fear, mistrust, and ambivalence about receiving help and moving forward.

Lack of trust is also a barrier. People who have experienced torture and trafficking are often reticent about disclosing personal information and may resist questioning from reception staff about the reason for an appointment. Build trust by explaining why particular information is needed and that disclosure of information can wait until the person is ready.

What health problems do forced migrants face?

Physical health problems

Forced migrants can present with signs and symptoms that are similar to those of the host population, but illnesses that feature more commonly are summarised below.[5]

- Depending on the person's country of origin, and their journey to and within the host country, there may be an increased risk of tuberculosis, HIV, malaria, meningitis, hepatitis, and measles. Uptake of infectious disease screening in their host country may be inhibited, however, by fear and stigma.
- Skin conditions, infestations, anaemia, vitamin deficiency (particularly vitamin D), malnutrition, and poor diet may result from poor living conditions and

Common psychological responses to torture

- Re-experiencing trauma—flashbacks, intrusive memories
- Avoidance and emotional numbing
- Hyperarousal
- Symptoms of depression
- Damaged self-concept and sense of foreshortened future
- Dissociation, depersonalisation, and atypical behaviour
- Somatic complaints
- Sexual dysfunction
- Psychosis
- Substance misuse
- Neuropsychological impairment (head injury, malnutrition)
- Effect on ability to parent

may be the cause of chronic low grade symptoms.

- Landmines, torture, or violent trauma may have caused fractures or musculoskeletal or soft tissue injuries, which may result in long term disability.
- Ophthalmology conditions might include retinal damage from forced solar gazing (a form of torture), corneal ulceration, keratitis and/or conjunctivitis from exposure to nerve gas. Glaucoma has a higher incidence in people of African heritage.
- Physical signs of torture may be minimal—eg, beating on the soles of the feet (falaka) results in extreme tenderness but rarely visible signs.

Symptoms that are medically unexplained

"The sorrow which has no vent in tears may make other organs weep"[6]—Tracy Ndovi

Psychosocial stressors, experienced by many forced migrants, can increase pain intensification and sensitivity.[7 8]

Although somatic symptoms may be caused by underlying stress, it is important to rule out other causes. For example, headaches could be due to a neck injury, post-concussion syndrome, traumatic brain injury, or post-traumatic epilepsy, and abdominal pain could be a consequence of *H pylori* disease or sexual assault. One cohort study notes a clear association between symptoms of pelvic and abdominal pain (in women and girls) and symptoms of anal pain (in men) and experience of sexual assault.[9]

Integrating physical, psychological, sociological, and cultural models into a therapeutic approach to chronic pain and weakness—eg, including massage, physiotherapy, non-steroidal analgesics, and training in self help techniques—can help with pain management.[10]

Psychological and mental health problems

"Tablets make me sedated and drowsy and when they wear off I am back to square one"
—Tracy Ndovi

Consider offering extended assessments to patients experiencing psychological symptoms. Recognising natural emotional responses to trauma and grief, maintaining an open mind and cultural awareness,and making judicious diagnoses help to avoid pathologising natural expressions of grief as mental illness.[12]

Psychological symptoms can present as extreme sadness, anxiety, depression, psychosis, panic attacks, insomnia, and nightmares. Substance misuse may be evident.

Post-traumatic stress disorder and other psychological problems may develop following experience of atrocities, multiple losses, and traumatic events occurring over extended periods. This might be compounded by more recent experiences of immigration detention and current experiences of social isolation, poverty, hostility, and loss of status.[13-15]

Depression among forced migrants is closely linked with poor social support[16]; immigration processes, racial discrimination, homelessness, and destitution can all have an impact.[17] A systematic review of the mental health implications of detaining asylum seekers confirms that child, adolescent, and adult immigration detainees experience high levels of anxiety, depression, post-traumatic stress, self harm, and suicidal ideation[18] A review of UK data has shown high levels of self harm and suicide among detained asylum seekers in the UK, compared with the UK prison population.[19]

Check whether any medication prescribed for psychological and mental health problems is helping, as medication may not always be the best solution. Supportive listening and offering practical assistance (eg, letting patients know that the Red Cross[20] tries to trace missing family) may be helpful. Offer referral for individual or group counselling. Counselling may be an unfamiliar concept to some people, so may need explanation in terms of helping them to understand and approach problems. Community programmes can offer psychosocial support.

Referral to specialised psychological services may be indicated for those with prolonged or severe symptoms, or who are at risk of harm to self or others.

Considerations for children

Children may be unaccompanied or with fragmented families. They may have experienced or witnessed violence, torture, or, as child soldiers, have been forced to perpetrate violence. Consequently, they may feel unprotected and believe adults to be untrustworthy.[23] They may show signs of developmental difficulties and experience anxiety, nightmares, bedwetting, withdrawal, or hyperactivity.

Young people can feel caught between the cultures of parents and peers[24] and families may need support to negotiate this.

Offer unaccompanied children support from social services with regular monitoring of needs assessment and care plans, including assessment of vulnerability to sexual exploitation and trafficking.

Child psychological functioning can be helped by stability and social support, education, school based mental health services, and support for the whole family.[25 26]

Children's immunisation histories may be incomplete—if there is any uncertainty it is advisable to start again, following the host countries' vaccination schedules.[27]

Torture

"I had no voice to express what had happened to me" —Theresa, 28, a client attending Freedom from Torture

Previous estimates of the proportion of asylum seekers who have been tortured ranged from 5% to 30%, depending on the country of origin,[29] but a more recent US meta-analysis suggests a higher proportion (up to 44%).[30]

Torture has specific sequelae and management.[31] Continuity of care, building rapport and trust, and allowing people who have experienced torture to retain control of the pace and direction of consultations can facilitate disclosure of torture experiences. Disclosure may be fragmented and people often under-report torture experiences because of dissociation, flashbacks, and shame (box).[33] Support may also be needed for the wider family, especially children.

Documenting sequelae of torture (particularly fresh lesions that may subsequently heal) can contribute important evidence, depending on the amount of time available to health workers, and the Istanbul Protocol provides specific guidance.[32] Careful documentation and reading of previously disclosed information avoids the need for people who have experienced torture to retell their accounts numerous times.[34]

Violence and harm based on gender or sexual orientation

"Talking about the things that have been done to you is just too painful and too shameful"—Tracy Ndovi

Female genital mutilation (FGM) can manifest as problems with childbirth, menstruation, recurrent urinary tract and pelvic infections, infertility, fistulas and keloid formation, and psychological sequelae.[35]

Sexual violence is experienced by both male and female survivors of torture,[36-38] people who have been trafficked,[39] and migrants in transit and refugee camps. Such violence can result in men doubting their sexuality, and women being perceived by their family and community as defiled and fearing honour based violence as a consequence of disclosure.

EDUCATION INTO PRACTICE

- How might you improve the accessibility of your service to forced migrants?
- What features would prompt you to inquire about female genital mutilation?
- When would you consider vitamin deficiency for chronic low grade symptoms?
- What community programmes can you recommend to forced migrants?

Migrant women may tolerate violent behaviour from a male partner because of his own experiences of violence, and/or may be fearful to report domestic and sexual violence. Continuity of care and offering a choice of gender for both health worker and interpreter can be helpful.

Women may face difficulties bonding with babies conceived through rape, and need sensitive support before and after the birth. Some women may choose to end a pregnancy that results from rape. This can be a particularly difficult decision for those from cultures where abortion is considered unacceptable.

Migrants in a same sex relationship might have been tortured and threatened with the death penalty because of their sexual orientation.[40]

Offer screening for sexually transmitted infection to people who have experienced sexual violence.

What social factors should you consider?

Culture and language

Health beliefs and health seeking behaviour are intricately affected by culture. Sensitive issues such as torture or domestic violence may be impossible to discuss with family members present. Longer or additional consultations might be needed.

If the patient and health worker do not speak the same language, offer a trained interpreter to avoid placing responsibilities on friends, family, and children.

Socioeconomic factors and occupational deprivation

Forced migrants face harsh living conditions and some are not allowed to work.[41 42] Those permitted to work may be inhibited by language barriers, unrecognised qualifications, and lack of work experience in the host country. Some may be too unwell to work and may need certification.

Participation in purposeful activities such as volunteering and contributing to health service development and provision can build self-confidence and community participation, as well as improving health services.[43]

Looking after caregivers

Anyone working with traumatised people can be affected. It reflects our empathy and humanity, and though intense, it may quickly dissipate.

Discuss persistent feelings to avoid them becoming destructive, impairing functioning, or resulting in burn out. Strong peer support, reflective practice, ongoing training, and a healthy work/life balance can help those caring for migrants to look after themselves.[45]

Competing Interests: The authors declare no relevant competing financial interests. They both work at Freedom from Torture with people who have experienced torture and organised violence. TN has lived experience as a forced migrant, survivor of torture, survivor advocate, and care manager for safe houses for people who have experienced domestic violence

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SPOT DIAGNOSIS
Chronic unilateral nasal congestion

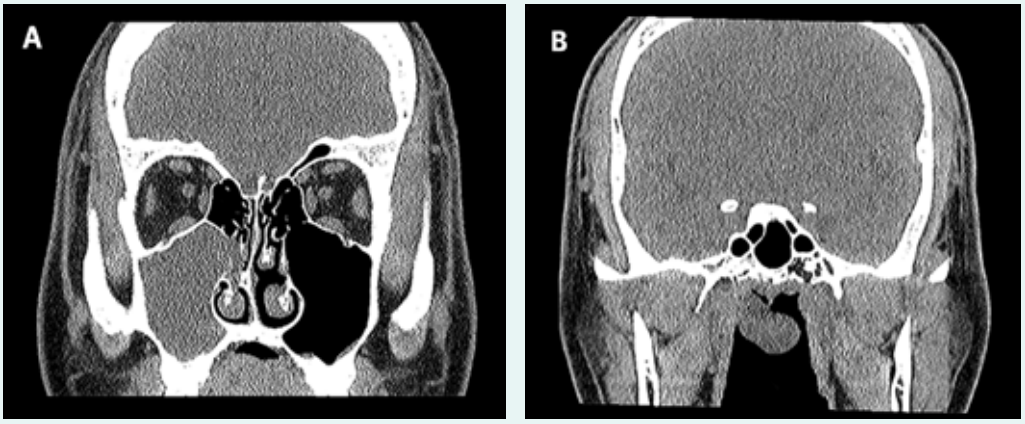

Fig 1

An 18 year old man was referred to the otolaryngology department with persistent right sided nasal congestion for one year. He had used a nasal corticosteroid spray in the six months before presentation, but his symptoms had not improved.
At the otolaryngology department he underwent a non-contrast computed tomography scan of his sinuses (fig 1). What is the diagnosis?

Submitted by Zhenxiao Huang, Jingying Ma, and Bing Zhou

Patient consent obtained

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answer

SPOT DIAGNOSIS Chronic unilateral nasal congestion

Antrochoanal polyps (ACPs) in the right sinonasal cavity (fig 2).

ACPs are usually unilateral and solitary. Generally, they are caused by mucus retaining cysts in the maxillary sinus. They typically extend into the nasal cavity through an ostium (opening) and fill the nasal cavity and nasopharynx. ACPs are the most common type of choanal polyp. They can also start in the ethmoid sinus, sphenoid sinus, rarely nasal septum, and inferior turbinate. ACPs represent 4-6% of all nasal polyps. They usually appear in younger patients, and represent up to 33% of nasal polyps in the paediatric population. Acinar mucous gland obstruction may be a part of the pathogenesis of ACPs.

The main symptoms are nasal congestion/obstruction and purulent nasal discharge. Nasal rhinoscopy or endoscopy, computed tomography, and magnetic resonance imaging are the techniques most widely used to diagnose ACPs.

Differential diagnoses of maxillary masses found in imaging include

- mucus retaining cysts (most frequent)
- adenoid hypertrophy
- ethmoidochoanal polyps
- sphenochoanal polyps
- turbinate hypertrophy
- angiofibroma
- sinonasal tumours (eg, olfactory neuroblastoma, inverted papilloma, haemangioma, malignancies).

The most common symptoms of sinonasal tumours are unilateral nasal obstruction, discharge that may be blood stained, and a reduced sense of smell.

Optimal treatment for ACP is by intranasal endoscopic sinus surgery, which has superseded simple polypectomy or with Caldwell-Luc procedure.

Learning points

- The most common presenting symptoms of ACPs are unilateral nasal congestion and nasal discharge
- ACPs should be considered in the differential diagnoses of nasal congestion

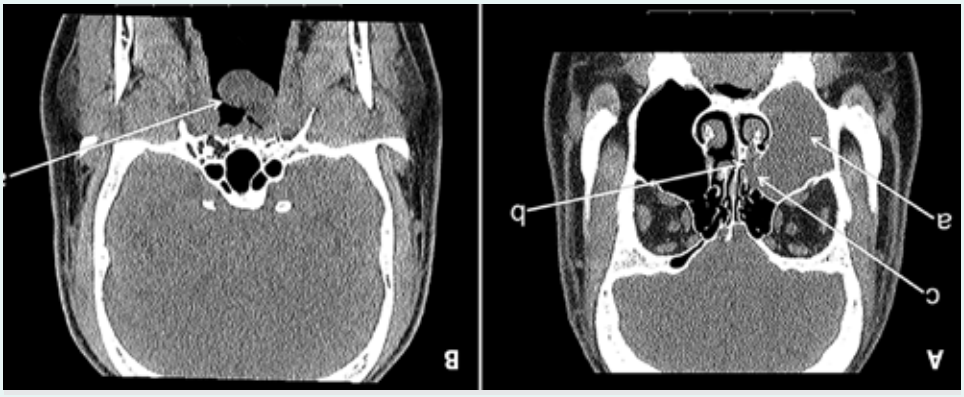


Fig 2 | Scan of the sinuses (coronal planes) showing typical soft tissue attenuation in the antrochoanal polyps, with complete opacification of the right maxillary sinus (A, arrow a), and extension of this opacification into the right nasal cavity (A, arrow b) through the enlarged right maxillary sinus ostium (A, arrow c) and nasopharynx (B, arrow a)

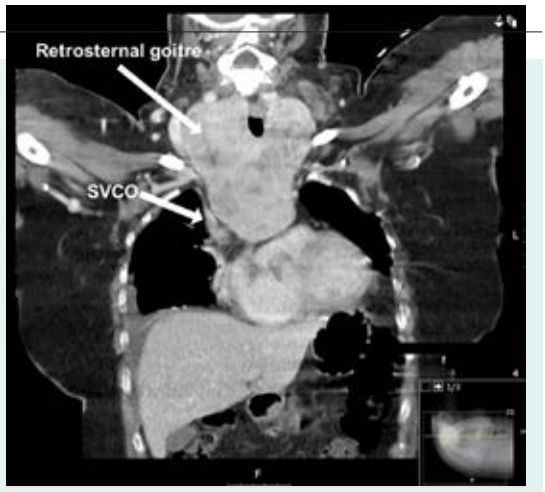
CPD READING
0.5 HOURS

You can record CPD points for reading any article. We suggest half an hour to read and reflect on each.

LEARNING MODULE

Articles with a "learning module" logo have a linked BMJ Learning module at http://learning.bmj.com.

Extended retrosternal goitre with superior vena cava obstruction



A 50 year old woman with a four week history of dyspnoea had neck swelling and a positive Pemberton's sign (arm elevation obstructs the thoracic inlet, leading to facial plethora). A computed tomography scan of the neck with iodine contrast showed partial superior vena cava obstruction secondary to a large retrosternal goitre (right). The patient was given 40 mg prednisolone and thyroidectomy was performed. Histology showed a 333 g benign multi-nodular goitre. After the operation her symptoms resolved.

Superior vena cava obstruction (figure SVCO) is an unusual complication of retrosternal goitre, more common in mountainous regions where the iodine content in soil is low.

Cross-sectional imaging with iodine containing contrast can provoke thyrotoxicosis. If available, consider magnetic resonance imaging.

Talisa Ross (talisaross@doctors.org.uk); Carole Collins, West Middlesex University Hospital, London

Patient consent obtained

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Religious observance and mortality

Large epidemiological surveys have found that people who regularly attend religious services have lower mortality than people who don't. Setting aside supernatural explanations, investigators used data from more than 5000 participants in the Health and Retirement Study in the US to explore what might be mediating the association (*Am J Epidemiol*). After controlling for demographic confounders, they identified social factors such as contact with friends and family and psychological factors such as increased life satisfaction and behavioural factors, which included taking exercise and drinking less alcohol.

Electronic cognitive behavioural therapy

Treatments that are effective, cheap, and safe are disappointingly rare. But electronically delivered cognitive behavioural therapy (CBT) may be an example. A large randomised controlled trial reports that digital CBT was highly effective in improving sleep, quality of life, and ratings of psychological wellbeing in people who had been complaining of symptoms of insomnia (*JAMA Psychiatry*). The intervention, which comprised six sessions of CBT lasting around 20 minutes, was delivered by web and mobile channels, and benefits were apparent by the time of the first evaluation at four weeks.

Dextrose injections for carpal tunnel syndrome

Compression of the median nerve at the wrist is one of the commonest peripheral neuropathies. Local treatment by perineural injection of corticosteroids is effective but the benefit is often short lived. A small trial from Taiwan raises the possibility that injection of 5% dextrose is as good, if not better. Improvements in pain and disability were similar in the groups allocated to dextrose and corticosteroid injection at one and three months but, evaluated at 6 months, symptoms were better in the group given dextrose (*Ann Neurol*).

Prolactin and diabetes

Prolactin has a wider physiological role than its name would suggest. Apart from lactation and other aspects of reproduction, evidence is increasing that the hormone influences metabolism and immune regulation. In the Nurses Health study, a large, long-running longitudinal investigation of women in the US, higher circulating levels of the hormone were associated with a lower incidence of type 2 diabetes (*Diabetologia*). After adjustment for body mass index, women in the highest quarter of the distribution of prolactin levels were 27% less likely to develop diabetes than those in the lowest quarter.

Painful colonoscopy

A large survey of patients who had undergone colonoscopy as part of a screening programme in Poland reports that propofol sedation is considerably more effective in preventing pain than benzodiazepine-opioid sedation, which was hardly better than no sedation at all (*Gut*). Using newer endoscopes and adequate bowel preparation also made pain less likely. However, the most striking finding was that the risk of painful colonoscopies varied 10 to 20-fold between endoscopists. This must surely mean that there's room for many endoscopists to improve their technique.

Cite this as: *BMJ* 2018;363:k4373