letters to the editor

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and sent by email to: Clinicalmedicine@rcplondon.ac.uk

Acute medical care

Editor – We read with interest the article by Ward *et al* (*Clin Med* December 2009 pp 553–6). In this article the authors identified a number of areas in which acute medical practice varies across different sites in a national survey. We have recently conducted a comprehensive regional survey in Wessex and have found similar variations. In our survey, responses were received from all nine of the acute hospitals in the region.

Eight of the nine acute units have at least one acute medicine consultant in post. The ability to recruit to these posts locally has been achieved, in part, due to the early development of a training programme in 2003. However, there remains a lack of uniformity in the structure of the services within this region. Even the titles of the units varied widely, with six different names being used; only one of the units had adopted the Royal College of Physicians (RCP) preferred title of 'acute medical unit' (AMU).

Although five of the nine units were purpose built, none had been able to achieve the 'emergency floor' model proposed in the RCP report, where co-location with critical care, emergency department and radiology was deemed desirable.[1] Near-patient testing was available in eight of the nine units, compared to <50% in the national survey. Six provided an ambulatory care service, eight provided direct general practitioner access and all used an early warning score for prediction of illness severity. Links with pharmacy were particularly strong in our survey, with all AMUs providing a dedicated pharmacy service. However, only one of the units was able to provide a dedicated AMU physiotherapist, and a weekend therapist was provided in only four units.

Ward *et al* emphasise the progress that acute medicine has made over the last 10 years, but a uniform service across the UK remains some distance away. Indeed, it is likely that their results underestimate the national variations given that 31% of the hospitals failed to respond. Hospitals without a coherent, structured acute medicine service may have been less likely to respond to an acute medicine survey. Collating data on a regional basis may be one way to achieve a higher response rate, as achieved in our survey.

MUHAMMAD ILYAS
ST5 acute medicine
Royal Bournemouth Hospital

MUHAMMAD ZAHID
ST5 acute medicine
Southampton University Hospitals NHS Trust

CHRIS ROSEVEARE
Consultant in acute medicine
Southampton University Hospitals NHS Trust

Reference

1 Royal College of Physicians. *Acute medical care. The right person, in the right setting – first time.* London: RCP, 2007.

A new era for stroke patients

Editor – The commentary by Smyth on the recent Royal College of Physicians stroke conference advocates computed tomography (CT) as first line imaging for acute stroke, rather than magnetic resonance imaging (MRI) (*Clin Med* December 2009 pp 557–9). We agree CT imaging is adequate for assessing patients for thrombolysis, but MRI of stroke is superior to CT.[1] With the use of limited sequences, rapid imaging is possible with greater accuracy than CT in the district general hospital setting and can be performed in the majority of acute stroke patients.[2,3] MRI also allows a more accurate determination of the vascular distribution of the event and the pattern of infarction can also provide clues to the cause of the event.[4,5] Multimodal MRI does not appear to carry the risk of multimodal CT scanning.[6] In our view, MRI is the optimal first line investigation for stroke and should be more widely used.

DENNIS BRILEY
Consultant neurologist

CHRIS DURKIN
Consultant physician

Stoke Mandeville Hospital, Aylesbury

References

1 Chalela JA, Kidwell CS, Nentwich LM *et al.* Magnetic resonance imaging and computed tomography in emergency assessment of patients with suspected stroke: a prospective comparison. *Lancet* 2007;369:293–8.
2 Tan PL, King D, Durkin CJ, Briley D, Meagher T. Diffusion-weighted magnetic resonance imaging for acute stroke: practical and popular. *Postgrad Med J* 2006;82:289–92.
3 Briley D, Meagher T, King D. Practical limitations of acute stroke MRI due to patient related problems. *Neurology* 2005;64:400.
4 Flossmann E, Redgrave JNE, Briley D, Rothwell PM. Reliability of clinical diagnosis of the symptomatic vascular territory in patients with recent transient ischemic attack or minor stroke. *Stroke* 2008;39:2457–60.
5 Wessels T, Wessels C, Ellsiepen A *et al.* Contribution of diffusion-weighted imaging in determination of stroke etiology. *Am J Neuroradiol* 2006;27:35–9.
6 US Food and Drug Administration. Safety investigation of CT perfusion scans: update 8/12/2009. www.fda.gov/medicaldevices/safety/alertsandnotices/ucm185898.htm

Are we dressed to impress?

Editor – The study from Gherardi and colleagues is both welcomed and timely (*Clin Med* Decmber 2009 pp 519–24). The physical appearance of doctors in hospitals has changed substantially over the past five years – the loss of the white