letters to the editor

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Anaemia investigation in practice

Editor – Mankodi and colleagues (*Clin Med* April 2010 pp 115–8) are to be congratulated for tackling the important issue of optimising investigational strategy in iron-deficiency anaemia (IDA). However, we would urge caution before extrapolating from their results and excluding patients from urgent gastrointestinal investigations if they do not meet strict criteria for IDA.

IDA is a continuum and, as Makondi *et al*'s results nicely illustrate, an increase in specificity is inevitably at the expense of decreased sensitivity resulting in missed cancers (false negatives). In the IDA group 4/14 (29%) patients with cancer had a ferritin >15 ng/ml, while in the non-IDA group at least 2/4 (50%) were in all probability iron deficient. This is alluded to in the discussion where they state that a ferritin threshold of <50 ng/ml increases the sensitivity for cancer detection to 94.4%. However, this is at odds with the central tenet of the paper demonstrating that applying strict thresholds for diagnosing IDA results in a reduction in investigations, and by extension, costs.

We have recently looked at the prevalence of anaemia in a sequential series of 87 patients diagnosed with right-sided colon cancer (caecal and ascending colon) at our institution between 2005 and 2008. At presentation, 72% of patients were anaemic according to the British Society of Gastroenterology criteria used by Mankodi *et al*. However, only 66% of these cases would have been classified as iron deficient using a ferritin level of <15 ng/ml, whereas this rose to 91% using a ferritin cut-off of <50 ng/ml. Therefore, approximately 25% of patients with anaemia secondary to a right-sided colorectal cancer have a ferritin of between 15–50 ng/ml, and would be denied urgent investigation using strict criteria. Furthermore, the mean cell volume is of limited value as, though a microcytosis is useful in suggesting the presence of IDA, 51% of our cohort had a normocytic anaemia. Of these, 58% had IDA using a ferritin threshold of <15 ng/ml, which rose to 83% using a threshold of <50 ng/ml.

Based on these and Mankodi's results we therefore advocate that rather than enforcing strict criteria for the diagnosis of IDA, using a ferritin threshold of <50 ng/ml significantly reduces false-negatives resulting in a higher cancer detection rate that outweighs the burden of increased investigations.

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NHS research governance procedures

Editor – Haynes, Bowman, Rahimi and Armitage (*Clin Med* April 2010 pp 127–9) usefully highlight the need for research governance procedures to be modified in order to improve the conduct of clinical research in the UK. A programme of changes to the research governance process has made further progress since the cases referred to in this article and is beginning to have a demonstrable impact on the practice of clinical research.

Significant progress has been made in streamlining research governance through the introduction of the Integrated Research Application System (IRAS) (January 2008), which provided a single entry point for permissions and approvals for health research in the UK. In addition, the National Institute for Health Research Clinical Research Network (NIHR CRN) has been working with the NHS and regulatory agencies since April 2007 on the Coordinated System for Gaining NHS Permission (CSP), which was introduced in the NHS in November 2008.

CSP is a managed system that uses a standardised, transparent and risk-based approach to NHS permissions for research, and is provided for every NHS trust in England through the NIHR CRN. CSP is streamlining trial set-up. There is evidence now that it is helping to quicken the process and increasing engagement by leading research and development departments is ensuring its continuous improvement. The introduction of the Research Passport scheme to simplify the contractual arrangements for researchers working in the NHS has also addressed one of the key delays in the study set-up process.

The North West Exemplar programme is demonstrating the impact NIHR CRN systems can have on commercial study performance and reliability. Although still in its early stages, the programme is impressing industry partners with set-up times – median time for approval of Exemplar studies is 53 days – and in several instances studies have recruited the first global or EU patient. Full data for phase one of the programme – focusing on effective study set-up – will become available at the end of June (http://nwexemplar.nihr.ac.uk/).[1]

The authors are correct in saying that post-permission study management issues – particularly recruiting to time and to target – need to be addressed, but the twin initiatives of the NIHR Research Support Service (RSS) and ongoing support for delivery of studies from NIHR CRNs will create a much more efficient research support system.

There is still much work to be done, but the NIHR has recognised the issues outlined in the article and is addressing them

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through a range of initiatives. For more information, see www.crncc.nihr.ac.uk

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Reference

1 Goodacre J. *Nature Med* 2010;16:158.

National Institute for Health Research Clinical Research Network

Editor – On entering medical school, we were taught that the most fundamental skill for a medical student to learn was how to elicit an accurate history from a patient, requiring communication skills, an inquisitive mind and above all, patience. Once the scene was set by the history, the examination would proceed to add depth, colour and clarity to the patient's story-board narrative. History taking should generate a hypothesis, which is either confirmed or refuted by the examination. This generates a working diagnosis, which leads to a minimum of appropriate tests to refine. After all, we can only run after we have learnt to walk.

Historically, this was what made medicine in Great Britain, great. Methodological reasoning and clinical acumen. Yet increasingly, we seem to have forgotten the works of William Occam, Reverend Bayes and Thomas Hutchinson, and have increasingly developed a 'test first, question later' mentality. We ignore the history, rush the examination and order a smörgåsbord of biochemical, haematological and radiological tests, fishing for a result and then treating it. We concentrate on the most serious or nebulous diagnosis, ignore the more common or more likely and often fail to consider a differential.

At the dark heart of this disintegration of medical practice in the UK is the fear of litigation and the perception of failure by 'missing something'. We prefer to believe in a seemingly flawless and objective 'test' rather than an imperfect and subjective 'judgement'. Making a rod for our own backs, we 'protect' the most inexperienced doctors from making judgements, expecting only those with more experience to do so, and in so doing de-skilling all concerned. Furthermore, a test might be positive but it is only of use and significance if we have a context in which to place it. Raised D-Dimer anyone?

Tests all have costs. For the organisation there are both financial and opportunity costs; for the patient there are costs in terms of morbidity (radiation exposure; complications of invasive investigation; hospital-acquired infection during the prolonged stay) and emotional harm, especially when putative diagnoses are raised which may result from false positive or negative tests. Inappropriate tests can also lead both to treatment that is unnecessary, and to more tests, often over a prolonged period (serial computed tomography scans following discovery of an incidental benign nodule) further increasing patient anxiety and potential morbidity.

Perhaps the biggest cost of ignoring the basic principles of the above approach to the patient is damage to our professionalism and to our profession *per se*. Doctors are trained to have the clinical skills to elicit the appropriate information. Judgement is then employed to weigh up that information effectively and efficiently to reach a diagnostic conclusion and make decisions about treatment.

The explosion of guidelines might be partly to blame. While they have their strengths, clinical guidelines do not foster a culture of the critical appraisal and evaluation of the usual disparate elements in the history and examination, which so often cloud diagnostic decision making. They are often rigid and straight-jacket thinking along specific lines; they are based on typical presentations, when in reality clinical medicine is rarely so straight forward. More importantly they are increasingly enforced by para-medical staff as rules not guidance. For a junior doctor to stray from a guideline leads to criticism and opprobrium from non-medical colleagues. To use guidelines, the critical appraisal skills for which a doctor has been trained are unnecessary. You don't have to be a doctor to use them.

Fundamentally, we all believe we hear the patient, but do we actually listen to what is said? We can diagnose a pulmonary embolus without touching the patient's bruised chest, cellulitis without asking if the patient's leg is normally swollen and red, and an acute coronary syndrome based only on a raised serum troponin concentration.

Perhaps we should bear in mind these commonsense maxims:

- Common things are common, but never say never.
- Treat acute things acutely and chronic things chronically.
- If a patient looks and feels well, they are well, despite what the tests say.
- If you allow them the time and space, the patient will tell you the diagnosis.
- If you hear the clap of hooves, it is probably not a unicorn.

We must embrace commonsense in medicine if we are to save our patients, our personal reputation, our profession and our NHS. How about a National Day for Commonsense in Medicine where the only available resource is our clinical skills?

We are all guilty of over-investigating – to cover ourselves, just in case, to 'rule out' unlikely alternatives when the answer is staring us in the face and trying to tell us. All the examinations, research and courses in the world cannot teach commonsense; this must be seen first hand in practice, by our students and juniors and we must take the time to teach this and teach it well, for we reap what we sow.

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Teaching and learning on busy post-take ward rounds

Editor – I read with interest the article by Graeme Dewhurst (*Clin Med* June 2010 pp 231–4). In the article, Dewhurst investigates those factors which are considered by junior

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