investigation rather than as an immediate investigation in the acute setting.

We would also like to thank Madan for the guidance, and we will look into the possibility of checking Taipan venom time in this patient.

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Hyper acute stroke unit services

Simon Liu and colleagues (*Clin Med* June 2011) should have clarified that the quoted number needed to treat (NNT) of 3.1 with thrombolysis did not refer to the more often used group outcome comparison of 'independent' versus 'dependent and dead', but to expert derived estimates for one additional patient to have a better outcome by one or more grades on the mRS (modified Rankin Score).[1,2] This would include patients moving from mRS 5 to mRS 4, for example, who would remain in the 'dependent and dead' category of outcome.

Jeffrey Saver's 2004 modelling paper concluded 'for every 100 patients with acute stroke treated with tissue plasminogen activator, approximately 32 will have a better final outcome and three have a worse final outcome as a result of treatment'. Thrombolysis has the potential to harm as well as cure! Saver also stated in the paper 'the NNT for tPA treatment to avert one case of dependence or death after stroke, defined as an mRS of 2 or more, is 8.4' based on the NINDS study.[2] A NNT of 8–10 is probably more recognised by physicians for the effectiveness of thrombolysis.

Work from Australia documenting the real-life three-month outcomes after thombolysis suggests that Saver's experts may have underestimated the benefits of thrombolysis in the group of patients presenting with more severe strokes.[3] Bray and colleagues in Melbourne found that of 24 patients presenting with stroke and a mRS of 4, the outcome at three months was that five of the group had an mRS of 0, 6 mRS of 1, 3 mRS of 2, 5 mRS of 3 and 1 an mRS of 4. Only four patients had a worse outcome with one dying (mRS 6) and three having a mRS of 5. For the 43 patients presenting with a mRS of 5 there were similar favourable improvements; 19 returned to independence (mRS 0–2) at three months post-stroke, with a further six dying and five remaining on a mRS of 5.

The access to hyper acute stroke care and thrombolysis in London has improved in recent years. Those people with severe strokes in particular need to get to hospital as soon as possible because early thrombolysis could make a major difference to their future care needs.

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The NHS: assessing new technologies, NICE and value for money

Editor – I read with interest Stevens' article (*Clin Med* June 2011 pp 247–50) giving an historical perspective of the inception of the National Institute for Health and Clinical Excellence (NICE) and development of its core activities. I would question, however, the assertion that NICE 'held its ground' over industry pressure to approve Relenza®, when less than a year after its first decision not to approve, it made a u-turn and approved (in admittedly a restricted way) the use of the drug for the following flu season, much to the horror of many GPs.[1] While the relevant paragraph is factually correct, as it refers to its 'first' decision, I would not want the casual reader to be unaware of the conclusion to that particular episode. NICE has had many question the legitimacy of its decisions made in a maelstrom of political and industry pressures.[2] One wonders whether an interpretation of the coalition government's plan to devolve rationing decisions to a more local level is an attempt to escape that perception.

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In response

Patel is right that NICE exists in a world of 'a maelstrom of political and industry pressures'. But it makes every attempt to remain fair and objective. Not least is the appointment of independent appraisal committees who are protected from most media exposure.

It is true that our Relenza® (zanamavir) for influenza decision changed between the very first (strictly pre-NICE) appraisal and technology appraisal No15 (TA15) a year later.[1] But then the evidence changed too. The first appraisal was informed by three randomised controlled trials, all three of which excluded 'at-risk' patients. The nub of the appraisal concerned precisely these patients – the immunocompromised, the elderly or those with other co-morbidities. In TA15 the evidence base included 800 at-risk individuals, including one trial of people with chronic respiratory disease. This was sufficient to reasonably model the effectiveness and cost-effectiveness of zanamavir not just on ameliorating an episode of flu, but in reducing the likelihood of exacerbating the co-morbidity.