

# letters to the editor

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## Endoscopy simulator training course: a delegate's view

Editor – The use of models and simulators is increasingly recognised as an important tool in endoscopy training and has been proven to play an important role in motivating junior doctors. The aim of this article is to provide detailed information on the endoscopy simulator training experience from a delegate's view.

### What are the aims of the course?

The course aims to provide aspiring gastroenterologists or gastrointestinal surgeons with an introduction to the essential core skills of endoscopy with hands on practical experience for oesophago-gastro-duodenoscopy (OGD) and colonoscopy procedures.

### Who is it for?

The course is aimed at junior trainees (core training level 1 or 2) both in medicine and surgery looking to apply for a specialist training post in gastroenterology or gastrointestinal (GI)/colorectal surgery. Foundation year 2 doctors can also apply to take the course.

### What is the course structure?

The course is delivered over one day. The morning consists of a series of short lectures discussing the theoretical aspects of endoscopy which include detailed information on the scope structure, design and function. The lectures also cover important aspects of endoscopy such as consent, indications, contraindications and complications. This is followed by practical workshops, practicing on models and simulators in the afternoon. These sessions allow participants the opportunity to gain hands-on

experience on the technical aspects of how to safely handle a gastroscope and colonoscope, with individual feedback from experienced faculty members. The main focus of the session was to enhance hand-eye coordination. The day ends with a session on JAG (Joint Advisory Group on GI endoscopy) registration and advises on future accreditation.

Lunch is provided as well as tea and coffee breaks throughout the day. The day is very relaxed and trainees are encouraged to participate as much as possible. Faculty members are either gastroenterologist or GI surgeons.

### How much did it cost?

The course costs between £150 and £250; the value of this varies depending on the location. You can use your study budget towards it. The best time to do the course is probably between the end of the first core training year and the beginning of second year.

### Where can I do the course?

A list of regional centres, dates and contact details can be found on the website ([www.jets.nhs.uk](http://www.jets.nhs.uk)). Those interested in attending can apply directly to these centres. The course is very popular and therefore it is important that you book your place as early as possible to avoid disappointment.

### Was it worth it?

It was definitely worth every penny. The combination of theory with hands-on practical sessions has helped me to develop an understanding of the important underlying principles of endoscopy as well as the hands-on feel of the scope. There was plenty of opportunity to practice on models

and simulators, which was extremely enjoyable. The faculty members were enthusiastic and approachable and were excellent in providing individual feedback.

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## Ulcerative colitis presenting as pyrexia of unknown origin (PUO) without bowel symptoms

Editor – I read with interest the case report by Khan *et al* of ulcerative colitis presenting as a pyrexia of unknown origin (PUO) (*Clin Med* August 2012 pp 389–90). In their clinical search for a cause of PUO they briefly mention a lesion of the lower leg which is described as a shallow leg ulcer with no clinical evidence of infection, but which grew methicillin-resistant *Staphylococcus aureus* and was treated with teicoplanin. No further details or sequelae are reported.

Ulcerative colitis is associated with the uncommon ulcerating skin condition pyoderma gangrenosum (PG). PG may affect any part of the skin, although the classical scenario describes a lesion of the lower leg in a female patient over 50 years of age, as reported by Khan in their case. While PG can be painful and debilitating, early or vegetative lesions can present simply as low grade leg ulcers in otherwise healthy patients. Skin biopsy shows a non-specific neutrophilic infiltrate but is only useful in excluding other differential diagnoses for painful ulcers such as vasculitis. Diagnosis is a clinical one based on the characteristic appearance of a rapidly enlarging, painful ulcer with a purple and undermined edge and a cribriform (colander-like) base.

The clinical diagnosis of PG should trigger a search to identify the 50–70% of patients who have associated disorders, including inflammatory bowel disease, arthritis and haematological malignancy. Treatment with high dose oral steroids and/or ciclosporin can be effective and response can be rapid. Indeed a response to oral steroids is one of the minor diagnostic

criteria used in this condition. Therapeutic trials of these agents in suspected multi-system inflammatory disorders can, therefore, inadvertently eradicate a useful cutaneous physical sign.

Fellows are reminded to consider atypical skin lesions when assessing and considering therapeutic trials in patients with suspected occult inflammatory or neoplastic disorders.

## Reference

- 1 Cox NH, Jorizzo JL, Bourke JF, Savage COS. Vasculitis, Neutrophilic Dermatoses and Related Disorders. In: Burns DA, Breathnach S, Cox NH Griffithes (eds), *Rock's Textbook of Dermatology*. London: Wiley-Blackwell, 2010.

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## Alternative therapies for asthma: are patients at risk?

Editor – Ernst and Posadski (*Clin Med* October 2012 pp 427–9) suggest scepticism is scientific virtue, but it is important to retain objectivity. This review appears to us actively hostile. The evidence of effectiveness for complementary and alternative medicine (CAM) in asthma is inconclusive, although ‘lack of evidence’ should not be confused with ‘evidence of lack’. Some interventions, eg breathing exercises and mindfulness meditation, have stronger evidence, and more and better-quality research is needed. The authors agree that asthma patients using CAM ‘often experience symptom reduction and less anxiety’. These appear useful outcomes, not to be dismissed lightly.

The authors suggest there is ‘considerable concern over the safety of some forms of alternative medicine’ including acupuncture which is described as ‘potentially life threatening’ with a ‘rare’ frequency of event. Endres *et al* prospectively analysed the adverse events in over 2 million acupuncture treatments.<sup>1</sup> They identified 14,000 events with no deaths or serious adverse events directly or circum-

stantially attributable to acupuncture. Calman suggests that we should consider this risk between minimal (vaccination-associated polio) and negligible (hit by lightning).<sup>3</sup> We are unsure why this data was not referenced and why this prevalence is a realistic hazard to patients. The statement that ‘the risk-benefit balance of these approaches is not positive’ could appear the opinion of commentators with a jaundiced eye.

There is also significant contradiction; the introduction states that CAM users use these approaches alongside conventional treatment and ‘there is evidence to suggest that the use of alternative medicine does not affect adherence to conventional asthma treatments’. Later the authors suggest ‘some patients might use it as a replacement for conventional treatment’ (unreferenced), with the emotive suggestion that CAM-induced non-adherence could result in death.

Many people with asthma are interested in exploring non-drug treatments and many report benefit. As clinicians we should listen to and understand our patients, and as scientists to undertake the methodologically challenging but important research needed to quantify the risks and benefits of non-drug treatments for asthma. Telling patients how silly they are being is unlikely to help anyone.

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## References

- 1 Endres HG, Molsberger A, Lungenhausen M, Trampisch HJ. An internal standard for verifying the accuracy of serious adverse event reporting: the example of an acupuncture study of 190,924 patients. *Eur J Med Res* 2004;9:1–7.
- 2 Calman KC. Cancer: science and society and the communication of risk. *BMJ* 1996;313:799.

## Response

I am, of course, pleased to see that this article attracted some attention, but I fear the authors of this comment might confuse a hostile with a critical attitude. Our brief review merely summarised the best available evidence on the subject and evaluated it critically. I strongly believe that an uncritical scientist is a contradiction in terms and I see reason to doubt that the commentators are critical in their assessments of alternative medicine.

For instance, they first cite the old chestnut that ‘lack of evidence is not evidence of lack’,<sup>1</sup> only to subsequently claim that, because there is a lack of evidence that alternative therapies are used as a replacement of effective treatments, there is no reason to worry. In a similar vein, they seem to play down the possibility of rare but serious harm from acupuncture, despite the fact that numerous fatalities have been reported in the medical literature.<sup>2</sup> Equally, they doubt that the risk/benefit balance of most alternative therapies for asthma fails to be positive, while dismissing an elementary fact: if a treatment is not demonstrably effective, even a small risk will tilt this balance into the negative.

Amazingly, the commentators even employ the old ‘argumentum ad populum’ which implies that, if something is used by many patients, it must be good. To end their comment, they then affirm ‘telling patients how silly they are is unlikely to help anyone’. As our article never stated anything remotely like this, this statement has many of the characteristics of a straw man.

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## References

- 1 Edzard Ernst: Absence of evidence is not evidence of absence, 2012. [blogs.bmj.com/bmj/2012/03/19/edzard-ernst-absence-of-evidence-is-not-evidence-of-absence/](http://blogs.bmj.com/bmj/2012/03/19/edzard-ernst-absence-of-evidence-is-not-evidence-of-absence/) [Accessed 7 December 2012].
- 2 Ernst E. Death after chiropractic: a review of published cases. *Int J ClinPract* 2010;64:1162–5.