References

1 Kilburn SA, Featherstone P, Higgins B, Brindle R. Interventions for cellulitis and erysipelas. *Cochrane Database of Systematic Reviews* 2010:(6);CD004299.
2 Bernard P, Chosidow O, Vaillant L. Oral pristinamycin versus standard penicillin regimen to treat erysipelas in adults: randomised non-inferiority open trial. *BMJ* 2002;325:864–8.
3 CREST (Clinical Resource Efficiency Support Team). *Guidelines on the management of cellulitis in adults.* Belfast: Crest, 2005. www.acutemed.co.uk/docs/Cellulitis%20guidelines,%20CREST,%2005.pdf [Accessed 3 April 2013].
4 Marwick C, Broomhall J, McCowan C *et al.* Severity assessment of skin and soft tissue infections: cohort study of management and outcomes for hospitalised patients. *J Antimicrob Chemother* 2011;66:387–397.
5 Chapman ALN, Dixon S, Andrews D *et al.* Clinical efficacy and cost effectiveness of outpatient parenteral antibiotic therapy (OPAT): a UK perspective. *J Antimicrob Chemother* 2009;64:1316–24.
6 Dryden M, Saeed K, Townsend R *et al.* Antibiotic stewardship and early discharge from hospital: impact of a structured approach to antimicrobial management. *J Antimicrob Chemother* 2012;67:2289–96.

Is research declining amongst gastroenterology trainees in the United Kingdom?

Editor – We read with interest the letter from Kurien *at al* regarding the decline in research output from trainees in the UK (*Clin Med* February 2013 pp118–9). Although they cite 'reduction of time spent within training programmes' as a reason for the decline, surely an important consideration is the colossal range of procedural hurdles the system has erected between trainees and simple research projects?

We had noted on an anecdotal basis that some patients (predominantly male) rather enjoyed a common medical procedure and some (predominantly female) did not. An interested registrar attempted to mount a small-scale study asking patients to rate their experience of the test on a linear scale from 1 to 10. We planned to collect data from around 60 patients to see if any pattern emerged.

Whether such an investigation should require ethics committee approval is surely debatable: nevertheless, we sought such approval as well as Trust R+D approval. The approval process required, inter alia: the Trust R&D application in XML and PDF format; an IRAS entry and SSI forms; curricula vitarum; patient information sheet and consent form; the actual questionnaire; data collection form; power calculations; detailed protocol; a full ethics committee application and subsequent detailed correspondence. The project was then sent out for peer review by the Trust.

Over 9 months later, we were finally given provisional permission to proceed, albeit with a patient information and consent pack on six sides of A4 paper. At this point, the study hit the problem of the requirement for the investigators to fund the stationery required to make up those packs. As the registrar had by then moved on, the project foundered.

It is no surprise to us that academic medicine is dying. As a society, we have allowed a system to develop that prevents trainees from following through a simple research project within a reasonable time scale during their training. Heaven help you if you wish to do anything so rash as a drug trial, even of an existing medication in a patient group for whom the drug is already indicated.

ANDREW L CLARK
Chair of clinical cardiology

G LOUISE BUCHANAN
Specialist registrar

Academic cardiology, Hull York Medical School, Castle Hill Hospital, Kingston-upon-Hull

Nicorandil and calcium antagonists: remember oro-anal ulceration and reflux cough too

Editor– Tarkin *et al* (*Clin Med* February 2013 pp63–70) have comprehensively reviewed the current drug treatment options in stable angina. With regard to their comment on nicorandil and calcium antagonists, it is worth reminding physicians of other commonly occurring side effects that may limit the ability of patients to take such medications in the long term.

With nicorandil, severe (but reversible on stopping the drug) oral[1] or perianal ulceration are both well described and can significantly impair compliance with the drug. A recent survey estimated 1 in 250 patients get anal ulcers, which requires discontinuing treatment.[2] In more serious cases, ulcers progress to fistulae into adjacent organs.[3] The mechanism is, as yet, unclear but may involve the effects of nicotinic acid on causing ulceration in the epithelium of healing wounds.[4]

With calcium antagonists, an underappreciated problem is reflux cough[5] due to attenuation of the lower oesophageal sphincter and reduced oesophageal clearance. Discontinuation of the drug for up to 3 months may be necessary. Reflux cough should be particularly suspected with cough on phonation, throat clearing after meals, or cough on rising/stooping (without dyspeptic symptoms).[6] In studies, verapamil and amlodipine seem to cause more reflux symptoms than diltiazem.[7]

In summary, be aware that a patient on nicorandil may present with unexplained oro-anal ulceration and, unless the offending drug is stopped, the ulcer may worsen and lead to fistulae. Regarding patients on calcium antagonists, discontinuation of the drug may be needed if reflux cough persists.

ANDREW RL MEDFORD
Consultant and honorary senior lecturer in thoracic medicine

North Bristol Lung Centre, Southmead Hospital, Bristol, UK

References

1 Healy CM, Smyth Y, Flint SR. Persistent nicorandil induced oral ulceration. *Heart* 2004;90:e38.
2 Colvin HS, Barakat T, Moussa O *et al.* Nicorandil associated anal ulcers: an estimate of incidence. *Ann R Coll Surg Engl* 2012;94:170–2.
3 Trechot P, Petitpain N, Guy C *et al.* Nicorandil: from ulcer to fistula into adjacent organs. *Int Wound J* 2013;10:210–3.
4 Trechot P, Claeys A, Petitpain N *et al.* Nicorandil and ulcerations: the Trojan horse? *J Eur Acad Dermatol Venereol* 2012;26:925–6.
5 Medford AR. A 54-year-old man with a chronic cough. Chronic cough: don't forget drug-induced causes. *Prim Care Respir J* 2012;21:347–8.
6 Morice AH, McGarvey L, Pavord I *et al.* BTS guidelines. Recommendations for the management of cough in adults. *Thorax* 2006;61:i1–24.
7 Hughes J, Lockhart J, Joyce A. Do calcium antagonists contribute to gastro-oesophageal reflux disease and concomitant non-cardiac chest pain? *Br J Clin Pharmacol* 2007;64:83–9.