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Response

We thank the reader for their clarification and raising this important point. They are correct in highlighting the concerns about the side effects associated with the few available treatments for nonalcoholic steatohepatitis (NASH), of which prostate cancer with vitamin E is an important one. This explains the very limited uptake of these drugs currently in clinical practice, and only weak recommendations for their use in guidelines.[1] There is an unmet need for safe and effective treatments for NASH, and the exciting developments with major phase III trials in this field will hopefully begin to address this in the near future. ■

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Gardening injuries

Editor – Sir Richard Thompson's excellent article *Gardening for health: a regular dose of gardening* in the June issue did not mention gardening injuries.

In 2007, the Royal Society for the Prevention of Accidents (RoSPA) reported that, in 2006, 87,000 gardeners required treatment in hospital for injuries caused by:

- lawn mowers (6,500)
- flower pots (5,300)
- secateurs and pruners (4,400)
- spades (3,600)
- electric hedge trimmers (3,100)
- plant tubs and troughs (2,800)
- shears (2,100)
- garden forks (2,000)
- hoses and sprinklers (1,900)
- garden canes and sticks (1,800).[1]

In 2009, an article was published entitled *Gardening? It's just as risky as rugby says doctors*. Gardeners attend clinics with ailments such as 'gardener's back', 'weeder's wrist' and 'pruner's neck'.[2] Dr Ian Drysdale, the principal of the British College of Osteopathic Medicine advised gardeners to:

- Start with some gentle stretching to warm up muscles and joints.
- Do no more than 1.5 hours per day initially.
- Kneel down when planting with both knees on a pad.
- Use a small spade when digging.
- Switch tasks regularly.
- When lifting, bend the knees and keep the back straight.

In 2010, an article was published entitled *Gardening riskier than skiing* and stated, 'One in ten Britons has been injured when gardening, four times as many as those hurt on the ski slopes'.[3] In the article, Dr Peter Mace, the assistant medical director of BUPA, was quoted as saying 'Anyone planning to spend time gardening or decorating should remember they may be using muscle groups and joints they haven't exercised in a long while'. ■

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Should point-of-care ultrasound be in the new internal medicine curriculum?

Editor – I read with interest the recent article by Smallwood and Dachsel entitled *Point-of-care ultrasound (POCUS): unnecessary gadgetry or evidence-based medicine?*[1] This article strikes a chord with me as someone who has recently finished core medical training who is interested in point-of-care ultrasound (POCUS), but struggled find the opportunity for supervised training and use. As mentioned in the original article, the indications and uses for POCUS are numerous but with currently limited uptake in the UK compared to the rest of the world.

The Canadian Internal Medicine Ultrasound (CIMUS) group recommend that POCUS gets incorporated into the internal medicine curriculum for four indications: inferior vena cava ultrasound to assess volume status, to assess the lung for B lines which would suggest pulmonary oedema, to assess the thorax for pleural effusion, and to assess for abdominal free fluid. It has been recommended to be incorporated to guide three invasive procedures: central venous access, thoracocentesis and paracentesis.[2] All of these surely would be a valuable string to the bow of the medical registrar of the future?

Core medical training is about to be revamped and lengthened, with a name change to 'internal medicine'. The programme will be increased from 2 to 3 years, with increased focus on acute medicine, increased outpatient exposure and mandatory placements in critical care.[3] There is no mention of any incorporation of POCUS into the curriculum; surely now is the ideal opportunity for a paradigm shift and for POCUS to be incorporated into the new internal medicine curriculum in a similar fashion to the Canadians? ■

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