

important as it allows for tailored lifestyle advice for the patient, screening of at risk family members and opens up the possibility of specific treatments targeting vitamin D production.⁴

In cases of hypercalcaemia, a renal tract ultrasound, looking for nephrocalcinosis, suggestive of a more longstanding kidney disorder, should be performed. Finally we would always advocate taking a detailed family history in such cases, irrespective of the patient's age, to identify any familial pattern of renal stones, nephrocalcinosis or hypercalcaemia ■

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Age adjusted D-dimers

Editor – I enjoyed the article by Dutton *et al*¹ who described the process of retrospectively creating an age adjusted D-dimer for the assay they used. The use of an age-adjusted cut-off has been successfully tested across a range of D-dimer assays, although a different Hemos assay was used in the study by Mullier *et al*.² It made me grateful that our hospital used one of the six assays

used in the original ADJUST-PE study³ which allowed us to rapidly adopt this strategy within our trust.

However, I am surprised that the authors used the three level Wells pre-test probability score. In 2012 NICE recommended using a two level Wells score (CG 144),⁴ using the terms 'likely' and 'unlikely' to replace 'high, intermediate and low' risk in the original Wells score. It would be a shame not to highlight the use of the more simple score for clinicians. It was the most cost effective scoring system, and easier to use (less chance of confusion about what to do with the intermediate group) and well validated when compared with a variety of pre-test probability systems.

If the authors are concerned that their assay was validated alongside the original Wells score (the only published evidence I could find for the HemosILTM D-dimer assay reference range used the two level Wells score with 512 patients)⁵ then the work they have done with 329 patients will allow them to compare the two and three level Wells scores at the same time. ■

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