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Reducing demand for computed tomography

Editor – I was interested in the article by Lewis *et al* in July on a nudge intervention aimed at reducing demand for computed tomography (CT).¹ While impressed with the reduction in CT requests, I was surprised by their decision to place the intervention (a message highlighting the radiation risk from the scan) in the report of scans, rather than earlier in the process of ordering a scan. In their discussion they state that ‘This approach was preferred to the alternative of delivering the information at the time of deciding to do the scan when it could impact on the efficient delivery of clinical care’. Their subsequent argument that it is difficult to go back to a patient and explain why CT may not be necessary is not entirely convincing.

As most radiology tests in the UK are now ordered electronically, computer physician order entry (CPOE) systems have the ability to display messages during the process of ordering a test. There is also the potential for CPOE systems to calculate individual risk (and display different messages) depending for example on the age of the patient or the number of previous CT they have undergone. It would be interesting to know whether such a system might have an even greater impact in reducing CT ordered, and particularly in younger patients who are at greater risk of cancer from ionising radiation. ■

DAVID R CHADWICK

Consultant in infectious diseases, James Cook University Hospital, Middlesbrough, UK

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The curriculum in general internal medicine

Editor – I note with interest that the current Joint Royal Colleges of Physicians Training Board curriculum in general internal medicine (GIM) is currently being reviewed and consideration is being given to current procedural competencies that are required from GIM registrars.¹

Currently, trainees must be able to perform abdominal paracentesis, direct current cardioversion and knee aspiration independently. Clinical independence is desirable for central venous cannulation (CVC) and intercostal drain (ICD) insertion for pneumothorax and pleural effusion. Under particular scrutiny will be CVC and ICD insertion and indeed a recent social media discussion from the Royal College of Physicians Trainees Committee generated much discussion surrounding these skills.

There is much regional variation in the frequency GIM trainees perform these procedures and the necessity that a GIM trainee would have to perform them in their local hospitals and deaneries. Some areas require medical trainees to perform both on a regular basis and they would often carry out these procedures for their own patients. Other hospitals have out-of-hours respiratory teams and CVC insertion is supported by anaesthetic and critical care colleagues. The requirement of pleural ultrasound for the insertion of intercostal drains for fluid, as described the British Thoracic Society,² further complicates matters. Training in both of these procedures varies and, to my knowledge, no formal training pathway for general medicine registrars exists. Concerns also exist over how ongoing competency should be reviewed and assessed for trainees who may perform these procedures less frequently or not at all.

Internal medicine training replaces core medical training this year.³ Junior medical trainees are now required to rotate through critical care. This could address some of the training, competency and confidence concerns regarding central venous cannulation early in medical trainees’ careers. Bedside ultrasound in medicine and its increasing popularity, alongside formalisation of its training (for example, focused acute medicine ultrasound),⁴ will also help. Ultimately, any curriculum change should reflect the requirements of both patients and trainees up and down the country and consideration should not only be given to these varying requirements, but to how trainees can easily acquire and maintain competency in these skills. ■

ADAM WILLIAMSON

Specialist registrar in acute and general medicine, West of Scotland Deanery, UK

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Dementia with Lewy bodies

Editor – I read with interest the ‘Acute presentation of dementia with Lewy bodies’ by Akintade and Pierres in the July edition of