

low folate for coeliac disease. With so many patients with low folate, it seemed that clinicians relied on clinical judgement to decide investigation and management plans, often not following guidelines precisely.

This was further exemplified in the audit investigating how often women were given appropriate advice on diet and exercise in their post-natal checks, where we also reflected on the struggle between the doctor's and the patient's agenda. During these sensitive but time-limited appointments, doctors had to decide what information to focus on, balancing patient preference and clinical judgment.

Lastly, carrying out projects such as in our questionnaire survey, showed us how patients differ in their ethnicity, age and body mass index; and how demographic parameters can impact the GP's approach.

It has been suggested that students do not perceive general practice as an academically challenging career choice.² Conducting quality improvement projects can change this perception.

In their conclusions, Butterworth and colleagues describe important initiatives to enhance the attractiveness of medical specialties.¹ Perhaps quality improvement projects for students supervised by an enthusiastic physician role model could also be considered. ■

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In the discussion points it is rightly pointed out that recanalisation of the superior mesenteric vein in the acute setting is vital. However, the authors go on to argue that mechanical thrombectomy 'should only be considered if the patient's condition continues to deteriorate despite anticoagulation' and surgery should be considered if there is evidence of bowel ischaemia.

It is important to note that surgical intervention is associated with worse short and long-term outcomes and prolonged hospital stays.² Intestinal infarction and bowel necrosis necessitating surgery is an endpoint that would indicate end-organ damage and treatment failure and therefore should be avoided.

As is the case with other acute, thromboembolic conditions such as pulmonary emboli and ischaemic strokes, it is recognised that medical thrombolysis may be able to achieve recanalisation more rapidly and improve outcomes in carefully selected patients.^{3,4}

Experience at a tertiary centre with thrombolysis in acute splanchnic vein thrombosis (SVT) has recently been published.⁵ The 22-patient case series highlights the potential role of tissue plasminogen activator and local clot dissolution therapy in preventing surgery. This approach may be indicated in patients with features of uncompensated bowel ischaemia as evidenced by clinical (eg poor resolution of abdominal pain, peritonism), biochemical (eg progressive lactataemia) or radiological (eg bowel loop dilatation or oedema) grounds. A step-wise thrombolysis protocol and early referral to a specialist hepatology centre should have a role in the treatment protocol for patients with SVT. ■

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Upper gastrointestinal bleeding in superior mesenteric vein thrombosis

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Editor – We have read the case report and accompanying literature review entitled 'Upper gastrointestinal bleeding in superior mesenteric vein thrombosis' by Phyu *et al* with great interest.¹ Although we agree with the authors' review of the literature, we feel there is more to consider in cases like this based on our experiences in a tertiary hepatology centre.

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