stoke from atrial fibrillation (AF).[1] Although ageism may certainly be relevant, the evidence would suggest that the underlying reasons are far more complex.

The overwhelming evidence in favour of oral anticoagulation from clinical trials is testament to the importance of this therapy as part of a stroke prevention strategy in high-risk patients with AF. Yet despite this, such therapy remains underutilised.[2] Naturally, the primary concern is of significant haemorrhage, but, lifestyle restrictions (eg alcohol), compliance, psycho-social implications, and the need to attend regular therapeutic monitoring are all factors in the decision on whether or not to anticoagulate.[3] Furthermore, up to 40% of patients express the preference not to receive anticoagulation.[4] Unfortunately each of these factors is more common in the elderly who similarly are also likely to have one or more other stroke risk factors such as prior stroke, hypertension, diabetes mellitus and congestive cardiac failure – reinforcing the need for adequate thromboprophylaxis in this patient group.[5] In addition, many physicians argue that elderly patients would not be able to manage the complexities of changes in dosage as is often required with warfarin.

How can things improve? It is important to remember that stroke can be a devastating event and many patients perceive a moderate-severe stroke to be a fate worse than death.[6] This is quite understandable, given that the outcome for stroke in AF is particularly poor with greater morbidity, mortality and fewer discharges to the patient's own home.[7] Thus an accurate assessment of stroke risk is mandatory. This process is aided by the various risk stratification tools and one of these is included as part of the current National Institute for Health and Clinical Excellence (NICE) guideline on the management of AF.[8]

Self-monitoring of anticoagulation may be helpful, particularly in the elderly (≥65 years) where this has been demonstrated to enhance the time spent within the therapeutic international normalised ratio range compared to clinic monitoring.[9]

Of paramount importance, however, is patient involvement in the decision making process. Due care should be paid to ensuring the patient understands both the risk of stroke and the risk of bleeding as a consequence of anticoagulation. Only then can an informed decision be made.

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Knowledge-based assessments: maintaining rigour in standard setting processes.

Editor – The editorial by Booth (*Clin Med* January/February 2007 pp 9–11) reviews the recent Joint Committee on Higher Medical Training pilot project on knowledge-based assessments for specialist registrars (SpRs).

The data on cardiology in particular provide insight into complexities involved in assessment processes and resultant outcomes. The cardiology cohort totalled 303 participants: 12 consultants and others of SpR-level grades. Booth comments that 'the pass mark for cardiology was clearly too high, probably because the standard setting process was not followed rigorously and was combined with question setting, editing and selection processes.' This raises some concern, as one essential element of standard setting processes is that they maintain sufficient rigour, and are as transparent and as defensible as possible,[1] especially with regards to high-stakes examinations that involve making summative decisions on performances, and have outcomes defined in terms of pass/fail decisions.[1,2]

Booth succinctly describes the Angoff process,[3] to which certain modifications have been made since its original description three decades ago. It is probably the most common method used for setting standards in assessments of the health profession.[1,2] The process is characterised by being: test-centred (in comparison to some other methods which may be examinee-centred), criterion-referenced (rather than norm-referenced), reliant on the judgements of experts/panellists, and requiring an understanding of the characteristics of the 'just-passing'/'borderline' candidates. As Booth stresses, defining the 'just-passing' candidate is difficult, even for experienced and expert panellists who have put considerable effort and time into the process. Each question for the intended examination undergoes stringent evaluation.

The fact that the overall pass rate was 4.8% for the entire cardiology cohort (with a pass rate of 8% of the participating consultants), raises possibilities that: (1) candidates truly performed badly in the pilot, (2) there was difficulty defining the 'just-passing' candidate for each question and/or for the whole examination, or (3) that the standard was set too high and therefore unrealistic (the pass *mark* was set at 83% for the 50 test items).

One modification to the Angoff technique that can aid, but not eliminate the difficulty of defining the 'just-passing' candidate, is that following the initial stages of pass mark determinations, panellists are provided with actual performance data

from prior examinations. For example, recent performances from the pilot tests (and in the future from actual examinations), would serve as a source of further information to panellists setting pass standards for their specialties. This allows an opportunity to review earlier decisions on the probabilities of candidates reaching the pass/fail standards. This iterative process introduces some elements of the examinee-centred methods, further increases the reliability and validity of the Angoff process and of the questions generated, and would support the attainment of realistic outcomes. The combined judgements of the individual experts in the group are used to set the standard.

No standard setting method is perfect,[4] and many are quite labour-intensive and time-consuming. However, any method employed should be fit for its defined purpose, be based on informed judgements, demonstrate rigour/diligence of process, be supported by best evidence medical education, and allow for both implementation and delivery of realistic outcomes.[5] Ongoing evaluation/quality assurance processes can serve as in-built mechanisms to promote continuous improvement and maximise on benefits of assessments. Jaeger *et al*,[6] commenting on standard setting for performance assessments, identify that 'the state of the art is far from a state of grace. Much work remains to be done.'

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In response

I agree with the main points raised by Ogundipe. My purpose in highlighting the problems with the standard setting in the pilot project was to draw attention to the need to use a rigorous, academically grounded process when preparing papers for real, high-stakes examinations. Standard setting for the MRCP(UK) written papers does currently follow a modified Angoff technique, similar to that described by Ogundipe, in which the previous performance of each individual question that has been used before is made known to members of the standard setting group before they reach their final verdict. This procedure has recently been reviewed by independent psychometricians and we hope to see a paper published shortly. It is expected that standard setting for new specialist examinations will build on this work.

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Kikuchi's disease

Editor – Qadri *et al* (*Clin Med* January/February 2007 pp 82–4) provide a comprehensive overview of Kikuchi's disease, a rare but difficult diagnosis with many differentials. My own experience was of a 27-year-old man from Pakistan who presented with a two-month history of general malaise followed by a four-week history of nocturnal fever, dry cough with occasional haemoptysis, weight loss and bilateral parotid gland and neck swelling. On examination he had obvious bilateral tender enlarged parotid glands as well as tender left anterior deep cervical adenopathy.

It is therefore important to remember Kikuchi's disease can present as parotid gland swelling which has been described previously, mimicking a parotid gland tumour.[1] In addition to the expected leucopaenia and elevated C-reactive protein mentioned by Qadri *et al*, he had perturbed liver function with an elevated alanine aminotransaminase (63 IU/1), which is also previously described.[2] It should be noted that pancytopaenia is also described.[2] Fine needle aspiration of the right parotid gland and affected cervical nodes revealed non-specific chronic inflammation but cervical node open biopsy confirmed the characteristic histiocytic necrotising lymphadenitis of Kikuchi's disease. His symptoms resolved spontaneously within two weeks.

In summary, Kikuchi's does also occur in men (although it is more common in women), symptoms can also include cough and haemoptysis, examination can reveal a parotid gland swelling mimicking a parotid tumour, bloods may reveal altered liver function tests and pancytopaenia. Open node biopsy is the gold standard for diagnosis showing histiocytic necrotising lymphadenitis with an absence of neutrophils and granulomas.[3]

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