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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