pregabalin by the European Agency for the Evaluation of Medicinal Products was based on 12 trials (eight unpublished), which showed that the drug was superior to placebo but inferior – in the only comparative trial available – to amitryptiline.[2] The approval of duloxetine relies on two short-term (12-week) trials with placebo as a comparator, without any formal comparison with other drugs used for the treatment of neuropathic pain.[3] While the supposed superior efficacy and tolerability of these drugs over tricyclics remains to be proven, there is no doubt about their superior cost to the NHS:[4] the incremental annual cost of the new drugs over amitriptyline (comparisons at maximum daily dosage) approaches 13 for duloxetine, 15 for pregabalin and 40 for gabapentin (although the cost of gabapentin is expected to be much reduced as soon as the generic formulation becomes available). We believe that for this money, the taxpayer, the doctor and, most importantly, the patient are surely entitled to a stronger evidence base.

PIERO BAGLIONI
Consultant Physician (Diabetes)
JYOTHISH GOVINDAN
Senior House Officer (Diabetes)
AFSHA KHAN
Senior House Officer (Diabetes)

Prince Charles Hospital, Merthyr Tydfil

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Neurological problems on the intensive care unit

Editor – Once again a learned article on coma (*Clin Med* April 2007 pp 148–53) fails to include cerebral malaria as a possible, and eminently treatable, cause. Several deaths from this occur annually in Britain because no adequate travel history has been elicited and the possibility of the diagnosis has not been considered. Clinical signs may include meningism, convulsions, paralysis of conjugate gaze, extensor plantar responses and retinal haemorrhages.

GEORGE COWAN
Former Medical Director
Joint Committee on Higher Medical Training

Where are you from?

Editor – I read your editorial with interest (*Clin Med* April 2007 pp 101–2). The account of a conversation with an Iraqi doctor described a healthcare system that was flourishing under Saddam Hussein until it was ruined in the aftermath of the invasion of 2003 and the subsequent lawlessness, kidnapping and murders.

I have had the good fortune to be in Baghdad twice in recent years. The first occasion was immediately after the regime change, when I spent an extended period working on public health and reconstruction with the new Iraqi Ministry of Health, which brought me into daily contact with a wide range of doctors, nurses and health officials. The second visit was for a briefer period in 2005 to discuss assistance to Iraq in updating clinical skills, which again involved frequent contact with clinicians. On neither occasion did I meet any Iraqis who shared the view put forward through the editorial that all had been well with health services before 2003.

On the contrary, I heard repeatedly of the systematic rundown of health services under Saddam and its devastating effects. Spending on health in 2001 was one-tenth of the level 10 years earlier, and I saw plenty of evidence of long-term decline with my own eyes in May 2003. I heard numerous accounts of the deliberate denial of vital drugs and equipment to sections of the population that had angered Saddam, and the memories of the distress of those who told me of the entirely preventable pain and suffering that resulted remain with me. From the time of the Iran–Iraq War, the borders were closed to most Iraqis, and accessing information from the outside world was forbidden. As a result, clinical skills stagnated as textbooks aged and could not be replaced, conference attendance became impossible, and training became outdated. Iraqi doctors were desperate to update their knowledge and skills – the reason for the work that we have been able to initiate and that occasioned my second visit. I heard that many of the brightest Iraqis did indeed continue to enter medical training – some things are difficult to change, it seems – but on qualification the best were compulsorily drafted into the Army medical services. Another strongly persistent memory is of being taken by a young ex-Republican Guard doctor to the prison camp he had been obliged to work in, with its gruesome torture chamber and large mass graves.

As a result of many conversations in Iraq as well as my own observation, I am sure that health services in Iraq were indeed well run and extremely capable – but only before Saddam came to power. By the time he was removed, they were in a very poor state indeed, even when not perverted as another cynical instrument of state control. The great majority of individual clinicians certainly did the best they could under desperately difficult circumstances, but the idea that there was a well-managed health system for anything but the favoured minority is unsustainable.

Of course nobody would deny that the terrorism and kidnapping since 2003 have disastrously set back attempts to improve life, health and well-being for Iraqis, as well as causing widespread human misery for those affected directly and indirectly. But to suggest that life was good under Saddam, or that services were well managed and effective, at best runs counter to the evidence; at worst, it risks offence to the great majority of Iraqis, many of them no longer able to speak for themselves.

BILL KIRKUP
Associate Chief Medical Officer
Department of Health

Personal viewpoint on revalidation

Recertification for specialists in the UK will be introduced over the next couple of years and seems likely to involve knowledge-based assessments and direct observation of procedural skills (DOPS). Most consultant physicians will be daunted by the

prospect of such assessments. Both authors have recently undergone both forms of assessment to allow certification to undertake colonoscopy for the national bowel cancer screening programme. This was quite an experience and probably reflects the stresses/rewards that revalidation will present.

Neither of us had sat an examination of any form for over 10 years, and certainly not had our clinical technique formally assessed by experts. The consequences of failing the certification exam (termed by some as the 'advanced colonoscopy driving test') were obvious. Firstly, our trust would not be able to start the screening programme and the considerable investments already made would come to naught – our recently employed screening nurse specialists would be at best twiddling their thumbs and at worst twiddling their P45s. Secondly, the blow to personal and professional pride/confidence would be huge. The implications of failing the 'driving test' from the point of view of an individual trust or professional society in the long run are as yet unclear.

Prior to the exam we had received a reading list, copies of the DOPS form that would be used, and the details of an exam preparation course. We spent many happy evenings learning polyp classifications, removal techniques, every conceivable configuration a colonoscope could get into and how to get out of them, to our wives' distraction. We examined each other to get used to the process and became obsessed with completion rates, polyp detection and sedation levels. We attended the preparation day which was held at the other end of the M5 and learnt how to use ScopeGuide (whereby the colonic knots formed during the endoscopy are visible for everyone, including the patient, to see), to have our technique constructively critiqued and to undertake a mock DOPS and a multiple choice question (MCQ) exam.

The exam itself was extremely nerve-racking – as bad as the MRCP(UK). One of us sat it at St Marks in London, the other in Torbay. One of our first patients had had a previous 'relatively easy' colonoscopy which on the day turned into an hour-long nightmare; thanks to ScopeGuide, the examiners were able to understand the complexity of the procedure. The patient also had a vasovagal episode during the procedure requiring a cool fan for both patient and examinee! The MCQ was tougher than the mock version, and then it was over. Over the next couple of weeks we learnt that we had both passed, and four weeks later the screening programme was up and running in Derbyshire.

We both found the process extremely stressful (and expensive!) but feel it has made us both far better colonoscopists. We have re-learnt many things we had forgotten, we have been watched by several experts and our technique has improved dramatically (making the procedure shorter and less painful for the patient). Our professional pride has been boosted by the process and we received nothing but positive and constructive feedback from the examiners (who, having been through the process recently themselves, were aware of the stress we were under and did their utmost to reduce it).

Although we did not enjoy the process, it was overall a very positive experience. We know, however, that there are some who have not passed the exam since it started and we empathise with the anguish they must be suffering. Revalidation will not be good news for everyone, but everyone should be better for it.

BOD GODDARD
ROB CUNLIFFE
Consultant Gastroenterologists
Derby Hospitals NHS Foundation Trust

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Management of chronic kidney disease: audit-based discussion

Management of chronic kidney disease (CKD) is gaining increasing significance. The guidelines laid out by the Joint Specialty Committee on Renal Medicine of the Royal College of Physicians (RCP), the Renal Association and the Royal College of General Practitioners recommends that all patients with stages 4 and 5 CKD be formally discussed with nephrologists even if renal replacement therapy is not anticipated.[1]

We audited management of CKD in Withybush Hospital, a district general hospital, which has no on-site renal services. We compared our practice against the standard set out in the guidelines.

Over a one-year period, 378 patients with abnormal renal functions were identified through our biochemistry department. Of these, 268 patients had either acute renal failure, acute or chronic renal failure, untreated obstructive kidney disease or stage 3 CKD and were eliminated. One was monitored by paediatrics and notes were not available for three patients so all four were also excluded. Of the original number, 106 patients identified to have chronic stable stages 4 and 5 CKD were audited.

Out of 106 patients, 61 (57%) were referred to nephrologists; 19 were diabetic with 14 (74%) referred; and 87 were non-diabetic with 47 (54%) referred. Sixty-two were aged over seventy with 26 (41%) referred and 44 were aged under seventy with 35 (80%) referred.

We found specialist opinion was not