letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk

Patient-centred medicine

Editor – Lewith's article on patient-centred medicine promotes notions that are debatable, to say the least (*Clin Med* June 2007 pp 250–2).[1] Lewith builds his arguments on the suggestion that NHS provision and scientific evidence are separate, largely unrelated issues. Policy is driven by political expediency and not by scientific evidence, he insists. I would counter that bad policy is driven by expediency and good policy by evidence. The fact that UK dentistry is in a mess is no reason to throw the rest of our healthcare in disarray as well. Simply because we made mistakes in the past, is no reason to justify blunders of the present or future.

Lewith states that the risks of complementary and alternative medicine (CAM) are 'exaggerated by those opposed to CAM' and they are negligible compared to the 784,000 deaths caused by adverse effects of conventional drugs. This line of argument fails to consider the concept of a risk-benefit balance. If a treatment is not more effective than a placebo, even relatively minor risks would tilt the balance. In other words, we must evaluate the risks and benefits of each form of CAM carefully. If we do this, some treatments come out as 'winners' and some as 'losers.'[2] General statements such as 'by and large CAM works'[1] are counterproductive and nonsensical.

Lewith claims the moral high ground of the 'wise physician'[1] and brands the critical analysts, 'top docs,'[1] as uncaring, arrogant scientists who are out of touch with real life. I fear that, if Lewith's views were adopted, we would not advance towards 'the best of both worlds'[1] but regress towards the quackery of pre-scientific medicine.

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References

1 Lewith G. Patient-centred medicine. *Clin Med* 2007;7:250–2.
2 Ernst E, Pittler MH, Wider B, Boddy K. The desktop guide to complementary and alternative medicine, 2nd edn. Edinburgh: Elsevier Mosby, 2006.

In response

I think it would be best for the readers of *Clinical Medicine* to decide whether they think current health policy is driven primarily by evidence or political expediency; those at the coalface of clinical practice would undoubtedly be in the best position to make this judgement. With the greatest respect I think non-clinicians who have not worked in the NHS for many years are not best placed to make judgements on this issue.

I continue to stand by the claim that processes which may alienate patients from their physician and drive complementary and integrated medicine into an 'alternative medical system' are not in the best interests of patients, medical communication or indeed medical safety. Perhaps your readership should be the judge of Professor Ernst's views.

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Normal pressure hydrocephalus

Editor – I recently wrote a report about my own case of normal pressure hydrocephalus (NPH) (*Clin Med* June 2007 pp 296–9). I described a happy ending to a long, sad story of misdiagnosis. In that report I failed to emphasise, as I intended, that incontinence is often the first clue to the diagnosis of NPH.

Over two years before the correct diagnosis of NPH was made I had developed urinary incontinence and, soon thereafter, faecal incontinence. I was referred to an urologist for the former and to a gastroenterologist for the latter. Both consultants thought my incontinence was caused by old age (76 years old).

When it presents as apraxia alone, NPH is difficult to diagnose. The appearance of incontinence in elderly patients should alert internists and surgeons, especially consultants, to the possibility of NPH, which is usually reversible. This diagnosis can be rapidly excluded by a computed tomography of the skull. Failure to think of NPH may doom such patients to prolonged, needless debilitation and death.

Normal pressure hydrocephalus is much more common than is generally believed. By word of mouth I have encountered more than 25 previously unrecognised cases in the four years since my shunt. Some of them, like me, are living healthy, productive lives.

Awareness that incontinence may be the 'breakthrough' symptom that leads to the diagnosis of NPH is an important issue. The diagnosis of NPH may make the patient's 'golden years' a bright, shining grand finale, rather than a tarnished bitter ending.

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Acute medicine CME section

Editor – We read the acute medicine CME section of the June 2007 issue with interest (*Clin Med* June 2007 pp 257–79). We were disappointed to see no mention of the role of interventional vascular radiological (IR) techniques in the contemporary management of acutely unwell medical patients. It is essential that your readers recognise the

importance of imaging and IR in the management of the critically ill patient particularly in the context of haemorrhage or vascular occlusion.

Transarterial embolisation is effective in rapidly arresting acute upper and lower gastrointestinal haemorrhage where this is not achievable endoscopically. It is quick and simple to perform, particularly if the site of bleeding has been marked (with clips) at endoscopy or has been identified with emergent computed tomography. Embolisation is as effective as surgery and is associated with a smaller physiological insult.[1] It is therefore preferable to surgery in these acutely unwell patients who often have multiple comorbidites and are usually significantly metabolically deranged. We suggest that any management algorithm should place IR ahead of surgery.

In acute massive and submassive pulmonary embolism, transvenous mechanical catheter thrombectomy can be lifesaving. Mechanical disruption quickly fragments obstructing thrombus, thereby reducing right ventricular strain, improving haemodynamic parameters and alleviating shock.[2] Mechanical thrombectomy also has the advantage of increasing the surface area of thrombus on which subsequent thrombolytic agents (which can be infused directly into the pulmonary artery) can act. In addition a filter can be placed in the inferior vena cava to protect against further pulmonary emboli.

It is important that clinicians are aware of these potentially lifesaving IR techniques. Unfortunately, rapid access to interventional radiology while on call is not universally available. There remains a challenge to interventional radiologists, physicians and surgeons to increase this availability if not within each hospital then by formal arrangement across one or more hospitals.

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References

1 Ripoll C, Bañares R, Beceiro I *et al.* Comparison of transcatheter arterial embolization and surgery for treatment of bleeding peptic ulcer after endoscopic treatment failure. *J Vasc Interv Radiol* 2004;15:447–50.
2 Skaf E, Beemath A, Siddiqui T *et al.* Catheter-tip embolectomy in the management of acute massive pulmonary embolism. *Am J Cardiol* 2007;99:415–20.

MRCP(UK) Part 2 clinical examination (PACES): examiners reflections

Editor – We enjoyed reading Larkin's provocative portrayal of the PACES examination (*Clin Med* April 2007 pp 203–4) in which he draws attention to some issues of importance. We were surprised, however by some of his 'ruminations'. We agree that many candidates spend too much time observing peripheral 'clues' and strongly suspect that this results from commercial PACES teaching. It often belies sufficient clinical experience.

We take issue with his comments about the assessment of communication skills in PACES. Surely Larkin cannot deny that communication with patients and carers is a critical skill for all doctors? Many complaints result from poor or inadequate communication. Any assessment of competence of trainees in medicine must include the ability to take and interpret the history and the ability to impart information and listen. The analysis of candidates' performance and examiners' judgements in 19 diets (over 24,000 candidates) provides compelling evidence that the station works well and identifies those with poor interviewing and communication skills. Indeed, the station has received strong support from the lay representatives on the Clinical Examining Board.

Most examiners do not share Larkin's difficulty with the actual examining process and commend the system and the marking scheme. The requirement for the two examiners to agree the physical signs and calibrate what they expect a competent candidate to achieve at the station has been welcomed. This calibration is obviously crucial and the start of the examination may be delayed if this task has not been completed.

The three parts of the MRCP examination are highly developed. Other countries, most particularly across the Atlantic, which use assessment by objective structured clinical examination rather than with real patients envy PACES and the evaluation of integrated clinical thinking it tests. The will to succeed in an examination drives appropriate trainee learning and skill acquisition, which, in turn, benefit patient care. It is a matter of pride that the written papers are taken in 25 countries and that the clinical examination is held in eight (nine from 2007); this demonstrates the international recognition given to the appropriateness of the examinations and their reliability, and is an acknowledgment of the importance of the standards set by MRCP(UK) examination.

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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.

Do we follow National Institute for Health and Clinical Excellence guidance for transient ischaemic attack and acute ischaemic stroke? An audit-based discussion

National Institute for Health and Clinical Excellence guidance

Management of stroke has evolved rapidly over the last few years. In May 2005, the National Institute for Health and Clinical Excellence (NICE) recommended the combination of low-dose aspirin plus modified-release (MR) dipyridamole for all patients with ischaemic stroke or transient ischaemic attack (TIA) even for