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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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