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.

CHRISTOPHER HAMMOND
Radiology Specialist Registrar
Yorkshire Deanery
DAVID KESSEL
Consultant Vascular Radiologist
Leeds Teaching Hospitals NHS Trust

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.

LAWRENCE G MCALPINE
Medical Secretary
PETER G KOPELMAN
Chair
Clinical Examining Board, MRCP(UK)
Central Office, London

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

the first episode as a secondary preventive measure. This therapy is for a period of two years thereafter to continue on long-term low-dose aspirin only.[1]

Practice in Withybush General Hospital

We audited our practice at Withybush General Hospital, Wales, against the above standard. Data were collected from 101 inpatients with ischaemic stroke or TIA. Seventy-five had a first episode, while 26 presented with a recurrence. Out of the 75 patients presenting with a first episode, only 9 (12%) were prescribed the combination, while 53 (71%) were prescribed aspirin alone. Three patients had clopidogrel and eight had warfarin. Out of the 26 patients with a recurrence, 16 (62%) were on the combination, while 6 (23%) were on aspirin alone. Plans for discontinuing dipyridamole after two years were not documented for any of these patients. It appeared that aspirin alone was preferred for the first event (71%), while the combination was preferred for subsequent events (61%).

Practice in Wales

By sending an e-questionnaire the opinions of various geriatric medicine consultants and specialist registrars regarding their practice were obtained (Table 1).

One hundred and one questionnaires were sent. Out of the 52 replies received, 22 doctors (41%) used the combination as a first-line treatment and most (65%) preferred to continue the combination for lifetime. Thirty doctors (59%) preferred using aspirin alone for the first event. The main reasons for not prescribing the combination were (percentage of doctors in parenthesis):

- intolerance due to headache with the combination therapy (23%)
- belief that the combination is useful only for stroke recurrence (23%)
- lack of strong evidence to support the combination therapy (17%)
- unaware about the recommendation (17%)
- aspirin alone has been the standard practice for many years (10%).

Table 1. Questions from the email questionnaire sent to geriatric medicine consultants and specialist registrars in Wales.

- What antiplatelet do you prefer to use for first ischaemic stroke or transient ischaemic attack?
- What is the main reason if they are not using the combination of aspirin and dipyridamole?
- How long do they use dipyridamole for?

The evidence for change

The NICE recommendation was based on the European Stroke Prevention Study (ESPS-2 study),[2] but the latest results from the European/Australasian Stroke Prevention in Reversible Ischaemia Trial (ESPRIT) study[3] combined with the results of the previous trials provides strong and sufficient evidence to support the combination therapy. We therefore have good reason to follow NICE guidance and change our practice accordingly. The duration of therapy is in need of review, however, as the combination can be continued long term if tolerated and if no contraindications develop.[4] Recommendations to use the combination therapy have been communicated to our medical department in Withybush General Hospital, and practice will be reaudited in 2008.

ALI AL-AMERI, *Foundation Year 1*
VINOTH SANKAR, *Senior House Officer*
K MOHANARUBAN, *Consultant Physician*
Withybush General Hospital, Haverfordwest

References

1 National Institute for Health and Clinical Excellence. *Clopdogrel and modified-release dipyridamole in the prevention of occlusive vascular events (TA90)*. London: NICE, 2005.
2 Diener HC, Cunha L, Forbes C *et al.* European Stroke Prevention Study 2. Dipyridamole and acetylsalicylic acid in the secondary prevention of stroke. *J Neurol Sci* 1996;143:1–13.
3 Halkes PH, van Gijn J, Kappelle LJ *et al.* Aspirin plus dipyridamole versus aspirin alone after cerebral ischemia of arterial origin (ESPRIT): randomized controlled trial. *Lancet* 2006;367:1665–73.
4 Sudlow C. Give dipyridamole with aspirin instead of aspirin alone to prevent vascular events after ischaemic stroke or TIA. *BMJ* 2007;334:901.

Deep vein thrombosis prophylaxis in medical inpatients. An audit-based discussion

Medical inpatients may have up to a 30% risk of developing a deep vein thrombosis (DVT) and a 1% risk of a pulmonary embolism (PE), which is similar to the risks associated with general surgery.[1] The National Institute for Health and Clinical Excellence (NICE) and the Royal College of Physicians (RCP) have emphasised the importance of adhering to good medical practice in the assessment and prevention of DVT in hospitalised patients. The risk should be individually quantified. The Seventh American College of Clinical Pharmacy (ACCP) conference on antithrombotic and thrombolytic therapy recommended that all medical inpatients should routinely be assessed for DVT prophylaxis.[2]

We audited our practice of DVT prophylaxis of medical inpatients in Withybush General Hospital, a district general hospital in Wales. For the purpose of the audit we adhered to the standards laid down by the Seventh ACCP conference for DVT assessment and prophylaxis (Fig 1).

A total of 102 medical inpatients were audited. Data were collected using the audit scoring proforma (Fig 1) and by screening individual patient records. Any patient scoring more than five on the scoring proforma, with no contraindications to enoxaparin, were considered eligible for DVT prophylaxis.

Of the 102 patients audited, 60 (58.8%) qualified for DVT prophylaxis with enoxaparin. Of those excluded, anticoagulation was contraindicated in 17 patients (16.6%) while 25 (24.5%) were already therapeutically anticoagulated with warfarin or enoxaparin.

Of the 60 patients included in the audit, 24 (40%) scored more than 5 on the scoring proforma and were considered eligible for DVT prophylaxis. Only five of these (20.8%), however, were on DVT prophylaxis with enoxaparin.