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

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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.

Our audit showed poor compliance to the standards of DVT assessment and prophylaxis. We recommend that patients admitted to medical units in the future should be routinely assessed for DVT prophylaxis on admission and that this should be offered to eligible patients. This pattern is currently being practiced successfully at many hospitals in Wales. We are planning to conduct a second audit six months after the implication of the recommendations.

MS BUTT, *Senior House Officer*
NI JOWETT, *Consultant Cardiologist*
SMU HAQ, *Consultant Physician*

Withybush General Hospital, Haverfordwest

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Fig 1. Audit scoring proforma.

Contraindications

Active bleeding
Cerebrovascular accident
Clotting disorders
Active gastric/duodenal ulcer
Chronic liver disease
Thrombocytopenia

Age >40	1	Anticipated bed rest rest >72 hours	2	OCP/HRT use within four weeks	2
Weight >80 kg	1	Severe COPD	2	Malignancy	3
Major surgery <6 months	1	Active IBD	2	Heart failure	3
Severe varicose veins/leg ulcers	1	Severe infection eg pneumonia	2	Myocardial infarction <3 months	3
Recent immobilisation	1	Post partum <1 month	2	History of DVT/PE	3

Score: If score is five or more, consider prophylactic treatment with enoxaparin 40 mg subcutaneous daily until patient fully mobile (14 days maximum).
Nurse recommendation for enoxaparin: yes/no

COPD = chronic obstructive pulmonary disease; DVT = deep vein thrombosis; HRT = hormone replacement therapy; IBD = inflammatory bowel disease; OCP = oral contraceptives; PE = pulmonary embolism.

lesson of the month

Kate M Evans
Specialist Registrar, Royal Cornwall Hospital, Truro
JAMIE SMITH

Jamie Smith
MD,Consultant Physician, Torbay Hospital, Torquay

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Complicated hypothyroidism?

A negative investigation does not necessarily indicate the absence of pathology. The pre-test clinical probability, and test sensitivity and specificity must be borne in mind when interpreting the result of any investigation.

Lesson

A 53-year-old man seen in the endocrine clinic with 'resistant' hypothyroidism had initially presented to his general practitioner 15 months earlier with fatigue, reduced exercise capacity, and myalgia, with a clear diagnosis of primary autoimmune (Hashimoto's) hypothyroidism: free T4 7.4 pmol/l (normal range (NR) 11–24), thyroid-stimulating hormone (TSH) 61 mIU/l (NR 0.35–4.5), thyroid peroxidase antibodies positive. Treatment with thyroxine 150 micrograms daily was commenced. Over the following year, he remained symptomatic, with ongoing biochemical hypothyroidism despite stepwise increments in thyroxine dose. Serum TSH eventually normalised on thyroxine 400 mcg/day. Prescription records did not suggest concordance issues. He was referred for an endocrine opinion.

In addition to fatigue, he reported longstanding problems with loose bowel movements exacerbated by stress, alcohol and fatty foods. There was no history of weight loss, past medical history or past family history. He had a normal body mass index, no goitre, no outward manifestations of systemic disease, and no detectable intra-abdominal pathology. Investigations suggested small bowel malabsorption (Table 1).

Coeliac disease was suspected, but no antiendomysial antibodies (EmA) were detected. The duodenum appeared non-specifically abnormal on endoscopic inspection. Histological examination demonstrated marked villous atrophy of the duodenum with an intraepithelial lymphocytosis, consistent with a diagnosis of coeliac disease. Serological testing for tissue