the background of society's evolution in the 20th century – the most rapid period of social change in recorded history. Many things combined to provide the opportunity for Sheila Sherlock's success – the rise of academic medicine as a discipline in the US and its importation into the UK, and the opening of a new clinical discipline with fertile opportunities for innovation. The book's value, however, is the insight it gives into the personality who was 'Prof', how she responded to those opportunities, and how that personality and her success developed against the 20th century tapestry. Who should read it? Today – anyone whose path crossed Sheila's; in the future – social historians with an eye to the original.

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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

Inhaled insulin

Editor – my editorial on inhaled insulin was published almost the very day that Pfizer announced the withdrawal of Exubera® because of its failure to achieve sales targets (*Clin Med* October 2007 pp 430–2). As my paper should show, I have reservations about the usefulness of Exubera.® The concept of an injection-free insulin regimen has, however, attracted patients with diabetes and the professionals who support them for decades and it is sad that the first clinically effective non-injectable should have had such a very short existence in the market.

The message conveyed by the withdrawal of a novel and effective (whatever its problems, Exubera® certainly works as an insulin!) agent so soon after its release because it did not receive enough of the market share in the time available is enormously worrying. The imperative for industry to make major financial gains on new developments within a short time of their release runs totally counter to the dictates of good medical practice, which demand that a new agent, with its inevitable high cost and lack of long-term safety data, should initially only be used in patients in whom the conventional agent is failing in some way – in terms of efficacy, patient acceptability or side effects – with slow replacement of older agents as and if it proves its clinical worth. The conflict between the needs of industry to recoup drug development costs and to provide returns for their investors and good medical practice need to be reconciled. Only a change in the way the market operates can achieve this. Unless we can change the way industry funds its drug development programmes, however, potentially valuable agents will either never see the light of day or be lost to us shortly after their release.

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Deep vein thromboprophylaxis in medically ill patients: poor compliance and limitations of guidelines

Editor – We could not agree more with Butt *et al*'s recommendations on thromboprophylaxis for deep vein thrombosis (DVT) in acutely ill medical patients in the hospital (*Clin Med* August 2007 pp 418–9). Hospitalised patients account for about 25% of the cases of DVT with more than half of these patients being medically ill.[1] We also found a similarly poor rate of compliance in assessment and prophylactic treatment for DVT in an audit carried out at Maidstone Hospital, a district general hospital in Kent. This audit was done to assess practice following an unfortunate fatal pulmonary embolism (PE) in a 27-year-old female patient with immobility of seven days duration secondary to a psychogenic paraparesis. She had no other medical illness, had no history of DVT/PE and was not on an oral contraceptive pill.

We collected data from the case notes and drug charts of 100 acutely ill medical patients and stratified the DVT risk for each patient according to Thromboembolic Risk Factors (THRIFT) consensus group guidelines (Table 1).[2] The majority of patients belonged to the moderate-risk category (91%). Only four patients were in the low-risk category. Of the 96 patients in the mod-