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-

Table 1. Deep vein thrombosis risk stratification.

Risk level	Patient group
Low	Minor medical illness
Moderate	Major medical illness: heart or lung disease, inflammatory bowel disease, cancer
High	Major medical illness in patients with previous deep vein thrombosis, pulmonary embolism or thrombophilia Lower limb paralysis

erate and high risk category only 48 patients received thromboprophylaxis for DVT (50%). Anticoagulation was contraindicated in eight patients in this group, but only one patient was given thromboembolic disease prevention stockings.

This audit showed a low rate of use of DVT prophylaxis in medically ill patients. This poor rate of compliance is unfortunately no different in the studies carried out across the UK.[3] Our recommendation was similar to that of Butt *et al* and we hope to find a higher rate of thromboprophyalxis when we carry out a second audit. Also, we strongly recommend that THRIFT and American College of Chest Physicians recommendations should only be used as a guide and the risk should be individually quantified especially in younger adults who may not score high on the risk sheets based on the above guidelines.

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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.

Testing for urinary infection using urinary reagent test strips in unselected acute medical patients

Urinary tract infections (UTIs) may cause typical urinary tract symptoms, but in the elderly population may lead to non-specific symptoms such as delirium. Prompt diagnosis of UTI may be aided by urinalysis testing for leucocytes and nitrites, but the use of these tests is primarily advocated in patients with urinary symptoms.[1,2] The usefulness of urinalysis testing in unselected general medical emergency admissions is unproven.[2–5] We have audited our use of urine dipsticking in adult patients admitted to hospital as emergencies.

The case notes and computerised laboratory results of 174 consecutive unselected acute medical patients admitted to hospital were studied retrospectively. The median (interquartile range) age was 75 (58–84) years. Of the 174 patients, 57 (33%) had urinalysis on admission. Urinalysis was considered positive for infection if leucocytes and/or bacterial nitrites were detected to any degree on dipstick testing of a clean catch urine sample.

Results

Urinalysis was more likely to be performed in patients whose clerking sheets documented urinary symptoms (frequency, dysuria, suprapubic pain, urinary incontinence) (11 of 21 patients) than in those without urinary symptoms (46 of 153 patients) ($\chi^2 = 4.17$, $p<0.05$). When tested, urinalysis was no more likely to be positive in those with urinary symptoms (6 of 11 patients) than those without urinary symptoms (17 of 46 patients).

After excluding those with urinary symptoms, urinalysis was more likely to be done in elderly patients with confusion/falls/'off legs' (16 of 37 patients, median age 80 (74–88) years) than those without (30 of 116 patients), ($\chi^2 = 4.03$, $p<0.05$). When tested, urinalysis was no more likely to be positive in those with confusion/falls/'off legs' (8 of 16 patients) than those without (9 of 30 patients).

Of the total 57 admission urinalyses, 23 were positive. Of these, 13 were cultured in the microbiology laboratory and only 5 were positive for significant bacteriuria ($>10^5$ bacteria/ml). Eight urine cultures were negative and in 10 patients the positive urinalysis was not followed up by microbiological culture. Despite infection only being subsequently confirmed in 5 of the 23 positive urinalyses, 7 of the 23 patients were started on an antibiotic specifically for UTI, 7 patients were commenced on a broad spectrum antibiotic that would cover a UTI and 2 patients were commenced on an antibiotic for a non-UTI diagnosis. Nine patients with positive urinalysis results received no antibiotics, suggesting the admitting doctors ignored the urinalysis result. Twelve of the 34 negative urinalyses were cultured, and all 12 were negative for significant bacteriuria.

Urinalysis is being used haphazardly in acutely admitted medical patients. Although it is done more frequently in patients who have specific urinary symptoms than those without, and in elderly patients with confusion/falls/'off legs' than those without such features, it is no more likely to be positive for infection in these settings. Reagent strip urinalysis is not useful in distinguishing UTIs in patients in these settings. The positive predictive value for a positive urinalysis is only 40%. A positive urinalysis frequently encourages the acute medical team to erroneously diagnose UTI, particularly in an elderly confused patient where a reversible organic pathology is enthusiastically sought. At worse a positive urinalysis may distract from the true diagnosis and encourage inappropriate antibiotic prescribing, with