Using the Pulmonary Embolism Severity Index (PESI) we found that up to 43% of patients with PE would be eligible for outpatient treatment.[2] As suggested by Aylin *et al*, age was significantly different in the low-risk and high-risk groups, 55 years and 77 years respectively ($p<0.001$). In the low-risk group 30-day mortality was 0 compared with 6.5% in the high-risk group. We calculated that employing an outpatient treatment strategy for low-risk PE as identified by PESI, would be safe and could account for a saving of 165 bed days per year at our district general hospital.

With growing pressure on inpatient resources the increasing rates of admission for PE could be safely cut by around 40% using entirely clinically based risk stratification indexes, to identify patients for outpatient management.

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Stranger on the shore – a personal view

Flying into London at night is one of the most beautiful sights, especially when seen for the first time through the eyes of a nine-year-old child arriving from Pakistan. To me it is as beautiful today as it was in 1959 when we first landed on these shores.

The view remains forever etched in my memory and even as I prepare to attend my first dinner at the Royal College of Physicians (RCP), having recently been made an Honorary Fellow, it all flashes before me again as I gaze out through the windows of my Canary Wharf penthouse and see the lights of London sparkling below me.

I walk into the classroom to be faced with a sea of white faces. I am a stranger on the shore, a shore which has seen very few strangers. A welcome, words of kindness, a gentle enquiry and a wish to share their world with me makes me feel very special. A welcome given to a special guest, 'Where do you come from?', 'Come sit next to me', 'Be my best friend?'. The school bell rings and I start my first day at school in Peckham, London.

I walk into the main hall at the RCP. I am a stranger on this shore. The hall is packed with the great and the good; notaries dressed with regalia each symbolising some part of the college's history, distinguished veterans of the College, dinner-jacketed and at ease with the events of the evening as though it were their own private dinner party. I am welcomed as a stranger – the face of the College is wise and old and mainly male. I am welcomed, hosted and escorted to my seat, introduced to guests on my right and left and made to feel the full welcome and hospitality given to a new guest.

I reflect how the landscape has changed in the schools over the last 50 years – who welcomes who now? The Bhangra, the Bollywood, and a concoction of Eastern food feasts seem to be the norm now in many school events – the welcome for the stranger on the shore is gone. Neighbours treat each other as outsiders, the humanity that binds each of us is forgotten somewhere in a dim past.

I look around at the College and reflect. What will the landscape be like here in the next 50 years? What will become of this house of ancient customs?

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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.

Inflammatory rheumatic conditions and cardiovascular disease

Inflammatory rheumatic diseases have been clearly linked to premature and accelerated coronary vascular disease (CVD).[1,2] This is thought to arise through the effects of systemic inflammation on lipid profile, insulin resistance, endothelial dysfunction and hypercoagulability, as well as the effects of physical deconditioning as a result of disability and the adverse effects of treatment.[3,4] There has also been recent focus on the role of C-reactive protein (CRP) and leptin as possible mediators of atherosclerosis in patients with systemic inflammation.[4]

It is therefore important for the rheumatologist to identify and treat modifiable cardiac risk factors. The objective of this audit was to investigate the frequency of cardiac risk factor monitoring in rheumatology outpatients, and to identify which patients had an appropriate record of pre-existing cardiac risk factors.

Method

Over a two-week period the medical records of 70 patients attending the rheumatology clinic at Charing Cross Hospital, London, were examined for evidence of the following standards of CVD risk factor monitoring, as suggested by Domsic *et al*:[3]

1 Weight taken and body mass index (BMI) calculated during clinic visit
2 Blood pressure measured during clinic visit
3 Lipid profile measured within one year, or six months if previously abnormal

4 Plasma glucose measured within one year
5 CRP measured within one year
6 Evidence that a history of the following cardiac risk factors was sought: hypertension, hyperlipidaemia, diabetes mellitus, smoking, family history of CVD and previous myocardial infarction (MI) or stroke (cerebrovascular accident, CVA).

Only patients with established inflammatory rheumatic conditions were included, the proportions of which are shown in Tables 1 and 2.

Table 1. Results of the two-week audit.

Condition	Number of patients (n=70)
Rheumatoid arthritis	33
Systemic lupus erythematosus	9
Polymyalgia rheumatica	7
Undifferentiated connective tissue disorder	7
Psoriatic arthritis	5
Sjogrens syndrome	5
Temporal arteritis	1
Ankylosing spondylitis	1
Juvenile idiopathic arthritis	1
Leucocytoclastic vasculitis	1

Table 2. Cardiovascular risk factor screening and record keeping of pre-existing risk factors.

Risk factor	Number of patients with risk factor appropriately measured (%)	Mean value in those measured
Weight	60 (86)	72.3 kg
Body mass index	0	NA
Blood pressure	3 (4)	120/67
Lipid profile	18 (26)	LDL = 4.9 TG = 1.6
Glucose	18 (26)	7.8
C-reactive protein	61 (87)	12.4
Risk factor	**Number of patients with adequate record of pre-existing risk factor (%)**	**Number with risk factor of those recorded (%)**
Hypertension	55 (79)	21 (38)
Hyperlipidaemia	56 (80)	14 (25)
Diabetes mellitus	56 (80)	3 (5)
Smoking	27 (39)	11 (40)
Family history	26 (37)	2 (8)
Previous myocardial infarction/stroke	50 (71)	2 (4)

LDL = low-density lipoprotein; TG = triacylglycerol.

Is cardiovascular risk factor screening adequate?

Although a high proportion of patients were weighed during their clinic visit, this was not used to calculate BMI. Blood pressure was only measured in a minority of patients. CRP was measured in the majority of patients, although this is likely to be due to the monitoring of disease activity rather than for cardiovascular risk stratification. Lipid profile and glucose were inadequately measured, although in those measured the mean values were within normal limits except for low-density lipoprotein, which was raised.

Is there adequate record of existing cardiovascular risk factors?

A large proportion of patients had adequate record of hypertension, hyperlipidaemia and diabetes, but information regarding smoking, family history and previous CVD was lacking. Of those assessed, a high proportion of patients had pre-existing hypertension and hyperlipidaemia, which is in keeping with the high cardiovascular risk in this patient population.

Conclusions

This audit indicates clear scope for improvement in cardiovascular risk factor screening in our outpatients. Although much of the identification and treatment of these risk factors occurs in the primary care setting, it is important for the rheumatologist to highlight the increased risk of CVD in this patient population and to ensure that modifiable cardiovascular risk factors are tightly controlled.

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