

1948 containing a short article describing how, despite sharing his Royal Palace, Munthe stopped speaking with King Gustav V for a period each year corresponding to the Swedish hunting season (of which the King was an enthusiastic participant). As someone who has visited Italy almost every year since I was born, I have been struck by the year-on-year increase in birdsong (and the correspondingly reduced biting insect life) in both countryside and city, as the Italians gradually wean themselves off blasting everything that flies out of the sky.

RICHARD QUINTON
Consultant and Senior Lecturer in
Endocrinology
Newcastle-on-Tyne

Reference

- 1 Munthe A. *The story of San Michele*. London: John Murray, 1932.

A history of the gardens of the Royal College of Physicians of London

Editor – I was delighted to read Arthur Hollman's article on a neglected area of the College's history (*Clin Med* June 2009 pp 242–6). May I make some minor additions to the story?

At Knightrider Street, the Royal College of Physicians (RCP) almost certainly did not have a garden on the premises. Contrary to the usual perception, the RCP did not own the whole house. After Linacre's death, the majority of the building, including the garden, was clearly the property of Merton College, the RCP having only two rooms at the front, the will stating:

And farther I will and bequeth the chappell and the chamber over the chappell wythin my howse where I now dwell wyth in the citie off London to the College of Phicicons of London and to ther successors for ever...

The College therefore would have had to look elsewhere for a garden.

At Amen Corner, there was undoubtedly a garden. In Stow's *Survey of London*, under 'Farringdon Ward, infra or within' he states that:

Now to turn up again to the north end of Ave Mary Lane, there is a short lane which

runneth west some small distance, and there is closed up with a gate into a great house; and this is called Amen Lane.

This is presumably the house which the College bought, and is shown on the copperplate map. However the copperplate map is somewhat misleading on the issue of the garden. As noted in the article, it probably dates from 1558, and in 1611 the Stationers' Company moved their hall from St Paul's Churchyard to 'Abergavenny House', or 'Bergavenny House' (rebuilt in 1654). This is referred to in all RCP legal manuscripts as forming the southern boundary of the College's site, and extended up to the City Wall, taking up the southern part of the garden shown on the copperplate map. The statement by Munk, referred to in the article, about a 'College garden...reached to the church of St Martin Ludgate' is actually referenced to McMichael's statement to this effect in *The gold-headed cane*,¹ and I can only assume that McMichael had deduced this from the later woodcut Agas map (which is based on the copperplate).

ANDREW HILSON
Harveian Librarian
Royal College of Physicians

Reference

- 1 MacMichael W. *The gold-headed cane*. London: John Murray, 1828.

Sepsis and septic shock: inching forwards

Editor – It was great to see the article by Jonathan Cohen and colleagues highlighting the large challenge that recognition and basic treatment of sepsis still brings (*Clin Med* June 2009 pp 256–7). I share their concerns that it is not part of the core competencies or syllabus for Modernising Medical Careers. Our sepsis audit, in keeping with a lot of national data, demonstrated the time to antimicrobials for patients with severe sepsis (any two of systemic inflammatory response syndrome (SIRS) criteria + one feature of end-organ dysfunction) was over seven hours in some cases. This prompted the production of a one-sided A4 document to be used as a

pro forma and audit tool; a sepsis guidelines/antibiotic prescribing guidelines card that is attachable to the trust photo ID badge.

In view of this we set up two sepsis symposia to promote early recognition and delivery of a sepsis care bundle. The symposium each comprised of three training sessions of a total of 24 doctors over a two-hour period.

Introduction

The introduction covered the audit data and the evidence for a need to change.

Session A: sepsis simulation with 'Sim man'

This session was based on a real scenario that had occurred a few weeks previously, when a patient with severe community-acquired pneumonia had not been treated with antibiotics or fluids for six hours and subsequently died. This was a 10-minute scenario for each team, culminating in improving observations/survival or a pulseless electrical activity (PEA) cardiac arrest depending on the group's ability to recognise and effectively treat the underlying sepsis. This was followed by structured feedback for each group.

Session B: the 'box'

This was a 20-minute brainstorming session where the junior doctors were asked to plan, construct and populate a box with the components needed to investigate and promptly treat sepsis. This resulted in the production of a 'suspicion of sepsis' box containing intravenous (iv) Tazocin®, 500 ml normal saline, a giving set, two cannulae, a blood culture phlebotomy pack, an arterial blood gas syringe, a tourniquet, water for injections and flushes. The juniors were also asked to formulate what should be written on the box with instructions, warnings and guidelines.

Session C: iv antimicrobial administration/blood culture phlebotomy/priming iv giving sets

This was a practical session involving a senior nurse teaching the juniors how to

mix and administer iv antibiotics. It was our philosophy that, the more clinicians who can give iv therapy, the better the chances of prompt treatment. The second part of the session was taught by a medical assistant who gave a practical demonstration of the optimal methods to obtaining 'clean' blood cultures. The feedback from the junior doctors has been universally positive and it is certainly something that is missing from the current curriculum.

The preliminary re-audit data following the symposiums have seen more than a 50% reduction in time to antimicrobials. For every hour antimicrobial therapy is delayed in a patient with severe sepsis there is an 8% increase in mortality, every second really does count.¹ Aside from the benefits of the more expensive and technical therapies and interventions that exist, the main priority remains, as it always has, early recognition and treatment.

MATT INADA-KIM

Consultant in Acute Medicine,
Royal Hampshire County Hospital

Reference

- 1 Kumar A. Duration of hypotension before initiation of effective antimicrobial therapy is the critical determinant of survival in human septic shock. *Crit Care Med* 2006;34:1589–96.

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.

Influenza vaccination: a cross-sectional prospective audit of influenza vaccination in patients admitted to a London hospital

Seasonal flu affects 5–15% of the population.¹ In the UK, the influenza vaccine is offered annually to those considered to be at risk and belonging to particular target groups which include people aged 65 and over, and those suffering from chronic diseases.² Influenza immunisation has been shown to reduce the incidence of

bronchopneumonia, hospital admissions and mortality.² The government aims to vaccinate more than 70% of 'at risk' individuals.³ Additionally, the World Health Organization has set a further target for vaccinating 85% of over 65s by 2010.³ The vaccination of clinically vulnerable people is becoming increasingly important as a flu pandemic has now been declared.¹

Methodology and results

An audit on the uptake of influenza vaccination among acute medical admissions, in a busy London teaching hospital, was undertaken in 2007 using a questionnaire survey. As a result of this audit, changes were recommended and the audit was repeated in 2009. The audit was conducted over a four-week period in winter 2007 and 2009. All patients belonging to an influenza vaccine target group were assessed for their vaccine uptake based on the questionnaire. Reasons for not receiving the vaccine were noted. This was audited against the Department of Health's recommended inclusion criteria for influenza vaccination.²

Table 1. A comparison of flu vaccine uptake in 2007 and 2009.

Year of audit	Patients in target group	
	Number who received the vaccine (%)	Number who did not receive the vaccine (%)
2007	82 (71)	34 (29)
2009	89 (74)	31 (26)

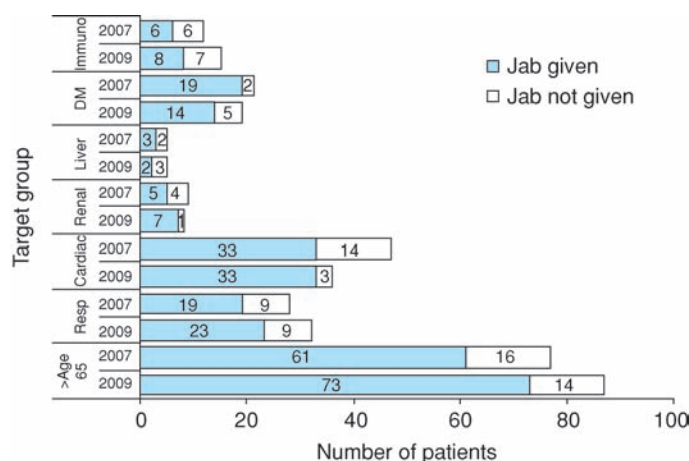


Fig 1. Comparison of each eligible target group and vaccine uptake over the 2007 and 2009 audits. DM = diabetes mellitus; immuno = immunology; resp = respiratory.