

In response

We thank Dholakia and colleagues for their interest in our paper. We agree there are other potential ways of providing a fast-track transient ischaemic attack (TIA) service. The small subgroup with high-grade symptomatic carotid stenosis is clearly important to identify and treat urgently; they derive unequivocal benefit from an urgent approach but represent only approximately 10% of patients with a TIA.¹ However, TIA services need to provide a more comprehensive assessment as outlined by the National Clinical Guidelines for Stroke. As a simple example, patients with atrial fibrillation will also benefit from a more urgent approach.

The advantages of a magnetic resonance (MR) imaging-based approach include:

- greater certainty of diagnosis²
- correct determination of the vascular distribution of the event. Clinicians may not be as good as they think they are in correctly determining the vascular distribution³
- a positive diffusion-weighted imaging (DWI) may also provide prognostic information in its own right⁴
- the pattern of infarction on DWI can provide clues to the cause of the event⁵
- MR angiography (MRA) can detect vascular disease at sites other than the carotid bifurcation eg vertebral and intracranial stenosis. Although not yet of proven benefit, interventional treatments for symptomatic stenoses at these other sites are now possible.

The national clinical guideline recommending urgent evaluation of high-risk TIA patients including DW-MR imaging is in line with other international recommendations.² We have now modified our service so that high-risk TIA patients are seen in a day hospital setting and undergo both MRI and MRA (when appropriate) within 24 hours of referral.

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Advances in infectious diseases

Editor – In his profound article Chris Ellis addresses what I too believe to be a myth, that ‘it is vital to complete the course of an antibiotic’ (*Clin Med* June 2009 pp 254–5). We are in good company as Harold Lambert, who was perhaps the most distinguished and wise infectious disease clinician of his generation, expressed this view in the *Lancet* in 1999.¹ The reasons for believing that most courses are too long were discussed informally in *Clinical Medicine* in the same year.² If the prevalence of bacterial resistance is directly related to population exposure to antibiotics and we are correct in our views, then to dispel this myth must be the surest and cheapest method of reducing the rate of development of bacterial resistance. A meta-analysis of the literature is unlikely to be helpful as most ‘short’ courses in published papers are themselves long in this context and stopping on recovery not allowed as an option. The studies needed to investigate this are fraught with potential

problems. They are not commercially attractive and liable to ethical and indemnity issues because of the perceived risk of under-treatment. Nevertheless they need doing but for these reasons can only be undertaken on the direction of the Department of Health or large national or international societies with the support of their governments. Should we not be pressing for them now?

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The value of the post-take ward round

Editor – The Royal Liverpool and Broadgreen Hospitals NHS Foundation Trust was one of the European Working Time Directive pilots for Skills for Health funded by the Department of Health. Their work has highlighted the benefits of clinical leadership and innovation with the creation of an acute response team for 24-hour emergency care. The learning from this has been widely shared www.healthcareworkforce.nhs.uk/liverpoolbroadgreenpilot/

In this study a number of parameters improved between 2006 and 2008 including the presence of the attending team on the post-take ward round (PTWR) (2.9% to 8%, $p=0.003$), diagnosis recorded in notes (82.7% to 88.9%, $p=0.02$) and the number of patients not receiving senior review fell from 3.2% to 0 ($p<0.001$).

The paper by Chaponda and colleagues highlights the benefits of increased consultant presence in quality of patient care and also emphasises the need for the restructuring of consultant working practices in order to deliver junior doctor training during the out-of-hours period ie outside of the traditional nine to five working day (*Clin Med* August 2009 pp 323–6).

The authors accept that by moving the PTWR to an earlier slot the night team