J R Coll Physicians Edinb 2009; 39:90–4

THE FUTURE OF THE COLLEGE LIBRARY

I read the letters associated with the future of the College Library (*J R Coll Physicians Edinb* 2008; 38:381–2) with some concern. First, I was uncertain that Dr Munro's conclusion, that the recent Library Appeal was about the enhancement of the College's historical collection, was soundly based. Certainly, the response from the President seemed to signal that the issue was not one of enhancement but rather about the survival of the activities associated with the College's quite exceptional historic collection, within the precincts of 9 Queen Street.

The evidence, such as it is, suggests that as Council has sought to address what the President has described as 'focusing on delivering a twenty-first century educational content and methods', the focusing process has revealed a significant cash-flow gap, in terms of perceived operational demand and available resources from existing College income.

What was absent from the President's helpful contribution to this correspondence was a clear quantitative signal as to the nature and estimated size of this cash-flow gap and a similar quantitative estimate as to what Council's current Library plans would make to addressing this gap.

Finally, I was a little anxious to note that the President has advised that Council now seeks, through the Library Appeal, to make the historical Library independent. What does this mean: independent of whom? It seems to me that there is good reason to seek clarification as to whether Council has taken the first step to ensure that the management of the activities associated with our unique historical Library collection are in the process of becoming beyond the control of future Councils. If this is so then I suggest there may be a need for a much wider and targeted consultation, which goes far beyond the recent excellent but more general survey of Fellows and Members.

John Cash
Retired Consultant and past President (1994–98), Edinburgh

President's reply

I can reassure Professor Cash that the only sort of independence sought for the library is, as stated in my earlier letter, 'financial independence' so that the College can use its current funds to deliver those services our Fellows and Members prioritise. The Library remains, and will remain, under the governance of the Council as one of our major assets.

Financial independence will require considerable new funding of the order of £5 million, which clearly will take much effort and considerable time to acquire, especially given the financial climate that has overtaken us. We are very grateful to the many Fellows and Members who have started the Appeal so well by donating £109,000 to the Sibbald Library Project. This will allow us to start the process of increasing the profile and accessibility of the collection; both are key to making best use of this resource and to increasing the chances of raising such a sum.

Neil Douglas
RCPE President

LIBRARY APPEAL

I have read the correspondence regarding my previous letter about the future of the Library (*J R Coll Physicians Edinb* 2008; 38:382) with interest. My previous appointments as the Registrar and subsequently as a Trustee are such that I have been kept informed about the College's financial position. However, I first served on Council as an elected member when Michael Oliver was the President. At that time there were informal discussions about the feasibility of offering the historical library to the National Library of Scotland (NLS), which was setting up its Science Department in Causewayside. These discussions came to nothing largely because the Royal Society beat the College to the draw and received the available funds.

Had the transfer occurred, it would have addressed many of the points raised by the Honorary Librarian. It would have enhanced the national standing of the College provided that the NLS agreed to publicise that the collection had been part-gifted (only a small part!). It would also have provided freedom of access to the collection for anybody interested in the history of medicine, resulting in the collection being fully catalogued and ensuring the long-term safe preservation of a national treasure.

The transfer would also have provided serious funding for other College activities. However, I am realistic enough to concede that the Fellows of that time might well have opposed any formal proposal.

It is my understanding of the President's letter that the current appeal is not really a Library Appeal. It is an attempt to reduce the financial problems facing the College by stopping funding of the running costs of the Library. If the Library is to be 'funded independently' either the appeal is going to have to raise enough money to pay for these costs from the interest and to keep pace with the next bout of inflation, or the appeal will have to be an ongoing exercise dependent on individual and corporate generosity. In the meantime there is a risk of decisions being taken that could be to the long-term detriment of the Library.

Surely the time has come to explore alternatives. Might it be worth approaching the National Library or even the Wellcome Trust to see if there is common ground to take things forward in a way that would benefit the College, the general public and the nation? At this stage

I continue to believe that the views of Fellows and Collegiate Members must be sought before taking irrevocable decisions.

John Munro
Retired Consultant, Musselburgh

ENDOBRONCHIAL ULTRASOUND-TRANSBRONCHIAL NEEDLE ASPIRATION AND LUNG CANCER

Dr WAH Wallace's recent paper 'The changing roles for histology and cytology in the management of patients with lung carcinoma' (*J R Coll Physicians Edinb* 2008; 38: 292–7) emphasises the potential utility of image-guided, minimally invasive techniques for staging the mediastinum, e.g. endobronchial ultrasound transbronchial needle aspiration (EBUS-TBNA). Regarding EBUS-TBNA, a couple of other points are worthy of mention.

Firstly, another justification for EBUS-TBNA over cervical mediastinoscopy is the potential cost saving to trusts by avoiding overnight admission and operating theatre costs as well as avoiding potential complications of mediastinoscopy (0.08% mortality and 2% risk of morbidity, especially supraventricular arrhythmias).[1,2] One pre-requisite in England in the context of Payment by Results, is a national adjustment of the EBUS-TBNA tariff; currently, the majority of EBUS procedures are coded as for standard bronchoscopy tariffs (unpublished observations), which attract significantly less reimbursement than a mediastinoscopy tariff (£,2211 vs £589).[3] Existing theoretical cost analyses suggest EBUS-TBNA will not be cost saving to trusts (about £26,000 cost to trust per year, despite £59,000 cost saving to the primary care trust), until the tariff is updated.[4]

Endobronchial ultrasound transbronchial needle aspiration may take up to twice the length of a standard bronchoscopy (depending on the number of nodal stations and whether a second normal bronchoscopy is performed for endobronchial biopsies at the same visit) and requires two operators in most centres using the technique and sampling the mediastinal lymph nodes; therefore, a mediastinoscopy tariff is the best approximation.

Secondly, on the basis of current evidence, the negative predictive value of EBUS-TBNA remains inferior to that of mediastinoscopy, hence the latter is still regarded as the gold standard mediastinal staging procedure in ACCP guidelines (although one recent study has demonstrated an impressive negative predictive value of 99%; however, the prevalence of nodal metastases was low at 9%).[1,5] Therefore, currently all negative EBUS-TBNA results must be corroborated by mediastinoscopy (this requirement may well diminish if future studies support an equivalent negative predictive value for EBUS-TBNA). However, re-mediastinoscopy performs less well after chemotherapy presumably because of fibrosis and adhesions secondary to chemoradiotherapy and previous mediastinoscopy.[6] Therefore, another potential role of EBUS-TBNA may be as the initial staging procedure, reserving mediastinoscopy for restaging.

Finally, recent data suggest EBUS-TBNA could have other applications in those with a normal mediastinum on CT and PET and even as a restaging tool itself (76% sensitivity), although the negative predictive value (20%) is poor here.[5,7] Both of these potential applications will require confirmatory studies. In addition, forthcoming trials comparing mediastinoscopy with EBUS may help clarify the relative merits of the two techniques, particularly pertinent to N2 disease with the impending revision of lung cancer staging.[8]

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SOME PERSONAL REFLECTIONS ON EXAMINING IN PACES

I read Drs Hafeez and Yusuf's paper 'Organising an MRCP course in Pakistan' (*J R Coll Physicians Edinb* 2008; 38:302–4) with interest and wish to add some thoughts of my own specifically limited to PACES. There is no doubt that the MRCP examination is an important function of the College.[1] I have been an MRCP examiner for 22 years and hosted the clinical section (PACES since 2001) for most of that time. The examination was mostly held on general wards because dedicated examination facilities were rarely available.

To my mind there are three 'problems' with PACES. Firstly, MRCP(UK) is an entrance exam for Higher Medical Training, but a worry is that in some countries MRCP is often taken to mean that successful candidates are partially trained.

Secondly, MRCP(UK) is reductionistic and does not assess abilities to cope with complex situations, although history-taking stations may to a limited extent assess abilities to deal with complex situations. The history station, logically enough, focuses on history-taking ability. When writing scenarios I tried to make history taking more usefully discriminatory. One scenario I wrote featured a young woman who had been seen several days previously in A&E because of a diazepam overdose and slashed wrists, and who was referred four days later because she had developed jaundice, monumentally high ALT levels but negative serology for hepatitis viruses. Only half the candidates realised the obvious diagnosis (covert paracetamol overdose at first presentation), although most had otherwise taken a good history. Pass or Fail?

In the examination-based stations, in which ten examiners make 14 assessments, candidates cannot be assessed on one patient with two problems. For example, in the CNS station I once put in an elderly patient with a hemiparesis who had an obvious facial rodent ulcer that only a few candidates noted, but sadly assessment had to be restricted to CNS aspects.

Thirdly, acute conditions are not assessed because PACES are mostly staged in designated areas. One consequence of using such areas is that patients usually have to be outpatients who are basically well and who have stable long-term conditions. I advise intending candidates that the conditions used are thereby limited and candidates should be well acquainted with 'the usual suspects'.

Cardiovascular system stations often feature heart valve abnormalities that are usually congenital or degenerative now that those with rheumatic heart valve disease have died off (degenerative aortic incompetence or stenosis/sclerosis regularly feature in my experience). Respiratory stations tend to have stable COPD or cryptogenic fibrosing alveolitis with clubbing and crepitations. Nervous system stations often have hemiparesis, multiple sclerosis, paraplegia from Spina bifida, Parkinsonism or (diabetic) peripheral neuropathy. Abdominal stations often have a liver and or a spleen or polycystic kidneys (often misdiagnosed as hepatosplenomegaly, despite evidence of haemodialysis and presence of a transplanted kidney). I used to include patients with chronic urinary retention (it is amazing how often candidates do not feel for enlarged midline organs such as the bladder or uterus). Eye stations are likely to have optic atrophy (and if nystagmus coexists the diagnosis is multiple sclerosis), diabetic retinopathy, retinitis pigmentosa or choroidoretinitis.

Often discussion is poor. Few candidates realise that 'pure' retinitis disrupts the retinal blood vessels, whereas 'pure' choroiditis does not. When asked to test visual acuity about half of candidates do not ask the patient to close one eye. One nervous candidate started to test visual acuity by asking the patient to close both eyes! If patients with both eyes open report impaired visual acuity, few candidates realise there must be visual impairment in both eyes.

Endocrine patients are difficult to find with the exception of patients with goitres with or without eye signs (who will hardly ever be clinically hypo- or hyperthyroid as they will have been treated), acromegaly or patients with steroid facies. Locomotor stations almost invariably include a patient with rheumatoid hands. Other choices include psoriatric arthropathy, osteoarthritic hips and ankylosing spondylitis (I once had a patient with ankylosing spondylitis who had ankle involvement – a case of spondylosing ankylitis then?). Skin stations will have psoriasis, scleroderma, occasionally cellulitis imported from the ward with an antibiotic infusion to help the diagnostically destitute or eczema.

Communication skills and ethics stations tend to focus on explanation of disease processes or breaking bad news. As noted by Hafeez and Yusuf, candidates are often deficient in talking skills, and in particular communication skills (the two are not the same). The only extra comment I would make is that we hardly ever assess or teach how good news should be imparted – not 'There has been a car crash involving your daughter and she has no major injuries' but rather 'The first thing is that you daughter is fine and there is nothing to worry about. She has been involved in a car crash…'

Marking is made as consistent as possible to ensure that assessments are standardised. I wish I were allowed a little subjectivity (I am human after all). My criteria for a pass is that I would allow the candidate to treat fellow examiners, and my criteria for a clear pass is that I would be happy to allow the candidate to treat me!

The exam is fair. One paper studying outcomes for UK graduates reveals that the exam marking is free from bias.[2] White candidates perform better overall than non-white candidates, and women perform better than men. 'It seems possible that in any postgraduate medical examination, female candidates will perform better at assessments involving consultation and communication.'[2]

Finally, mention has to be made of Mrs L Tedford, known to everyone as Lindy, who administrates the Edinburgh exam. She could organise examiners for PACES during a tsunami following an earthquake in a war zone. I have a personal belief that she has a computer-assisted telephone attachment for contacting potential examiners such that she can be perceived simultaneously to be a

J R Coll Physicians Edinb 2009; 39:90–4

combination of assertive, about to burst into tears and under intolerable stress that only you can relieve by agreeing to examine.

Philip D Welsby
Retired consultant physician, Edinburgh

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THE USE OF IV PROTON PUMP INHIBITORS IN UPPER GASTROINTESTINAL BLEEDING

We read the clinical opinion by JN Plevris on 'intravenous administration of proton pump inhibitors (IV PPI) in upper gastrointestinal (UGI) bleeding' with interest (*J R Coll Physicians Edinb* 2008; 38:326–7). We have previously published our own clinical opinion on the subject.[1]

The Canadian paper reviewed by Plevris demonstrates the phenomenon that therapeutic strategies are often misused by non-specialists. However, in this case, the alleged misuse of IV PPI appears to have benefited patients.

Plevris recommends that the decision to use IV PPI prior to endoscopy should only be made by a specialist gastroenterologist if endoscopy is delayed or for selected high-risk patients. This contradicts the message from the Canadian experience where benefit was gained from non-specialists prescribing IV PPI in a wide range of situations.

It is overnight and at weekends when a patient presents with an UGI bleed to a hospital with no out-of-hours endoscopy service that pre-endoscopy IV PPI have the most potential to benefit – the very times when it is unlikely that there is a specialist gastroenterologist present.

Widespread misuse of IV PPI when the oral version would suffice or for indications such as abdominal pain is clearly erroneous and should be avoided by local education and clear guidelines.

Our recommendation is that IV PPI should be prescribed prior to endoscopy to patients with overt UGI bleeding unless endoscopy is available within a few hours.

[1]Tom Lee, [2]Deepak Dwarakanath
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Author's reply

I would like to thank Drs Lee and Dwarakanath for their comments. I do not feel that there was any contradiction between the findings of the Canadian paper and the comments in the clinical opinion, as I was keen to incorporate a degree of caution in the interpretation of the findings of a study that is a retrospective audit with inevitable methodological deficiencies.

I will reiterate what I have stated in my clinical opinion: in selected cases of high-risk patients, who are mostly presenting as significant overt bleeding thus likely to be started on IV PPI after the endoscopic intervention, and in those where an endoscopy is likely to be delayed, it is reasonable to prescribe IV PPI prior to endoscopy. In that respect, I am in agreement with Drs Lee and Dwarakanath.

So far the data available on early use of IV PPI have not demonstrated any reduction in mortality, rebleeding or need for surgery. For this reason, IV PPI should be used after endoscopic therapy, as recommended by the most recent SIGN guideline.[1] A gastroenterologist should be involved in the decision to prescribe IV PPI prior to endoscopy, until more data are available from prospective trials. Such involvement depends on the individual hospital; in hospitals that do not operate bleeding out-of-hours rotas, clear guidelines drawn by the local gastroenterologist for the on-call team are necessary for the appropriate use of IV PPI.

I would like to take this opportunity to highlight some recent data regarding increasing incidence of *Clostridium difficile*-associated diarrhoea in relation to increasing use of PPI.[2] A recent editorial by Cunningham et al.[3] recommends being cautious in the use of PPI in hospitalised patients, as the higher the acid suppression, the higher the risk of vegetative *C. difficile* cells surviving in patients' stomachs.

As a final point, the early use of IV PPI should not sidetrack from the need to offer early endoscopy and definitive treatment to patients with an UGI bleeding, and all hospitals treating UGI bleeders should work towards offering emergency endoscopy on a 24-hour basis.

JN Plevris
Consultant Gastroenterologist, Royal Infirmary of Edinburgh

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COLLEGE NEWS

Presidential knighthood

Our President was awarded a knighthood in the New Year's Honours list for services to medicine. We congratulate Sir Neil Douglas.

Editorial staff change

Dr Niall Finlayson, Editor, and Prof. John Kelly, Clinical Editor, retired in February. Our new appointments are: Dr John Simpson, Editor, Dr Gillian Mead, Assistant Editor, and Dr Robert MacFadyen, Clinical Editor.

Dr Simpson specialises in respiratory disease, Dr Mead in geriatrics and Dr MacFadyen in cardiology.

Journal contents

Medibytes and Ex libris have not appeared in this issue owing to pressure on space.

College appointment

Dr Deepak Dwarakanath, a consultant gastroenterologist, has been appointed Secretary in succession to Dr John Collins.

COMPUTER-AIDED LEARNING AND THE ASSESSMENT OF STUDENT PERFORMANCE

Narayanan et al. are to be congratulated on their efforts to evaluate computer-aided learning (CAL) as a means of training doctors (Narayanan RP, Kirk P, Lewis S. Uptake and perceptions of an e-learning package on blood transfusion by trainees in Wales. *J R Coll Physicians Edinb* 2008; 38:298–301). Following recent changes to UK medical training, there is now no 'typical rotation' – leading to variable learning experiences among junior doctors – and trainee access to formal teaching is incomplete.[1,2] Computer-aided learning might help by delivering standardised teaching at multiple locations and at doctors' convenience.

Narayanan and colleagues focus on usability and uptake. They note only in the last paragraph of their article the need to demonstrate the 'acquisition of required skills' in the evaluation of CAL. This latter issue is more difficult to address.

We recently developed a CAL package to teach undergraduates the WHO International Classification of Functioning, Disability and Health (ICF)[3] – the global standard for describing health status. We demonstrated high levels of uptake and usability but, in addition, evaluated impact on learning. We used a two-group study design, comparing students in successive academic years. Both cohorts received a 30-minute lecture on the ICF and one received the CAL package. Other teaching remained the same between cohorts. Students were asked to complete a structured case report, one section of which required application of the ICF. The marking scheme covered all five domains of the ICF, with one mark awarded for the correct use of each, giving a possible score of 0–5. Case reports were anonymised before marking, with the year of study not revealed until analysis.

A total of 103/178 students pre-CAL were compared with 175/216 post-CAL. The remaining case reports were missing. There was no difference in demography or academic achievements between cohorts. The median score pre-CAL was 2 (0–4) and post-CAL was 3 (1–4); see Figure 1. The proportion of students scoring ≥ 3/5 marks rose from 49% (50/103) to 59% (103/175) post-CAL. Scores were increased by a similar amount across all ICF domains.

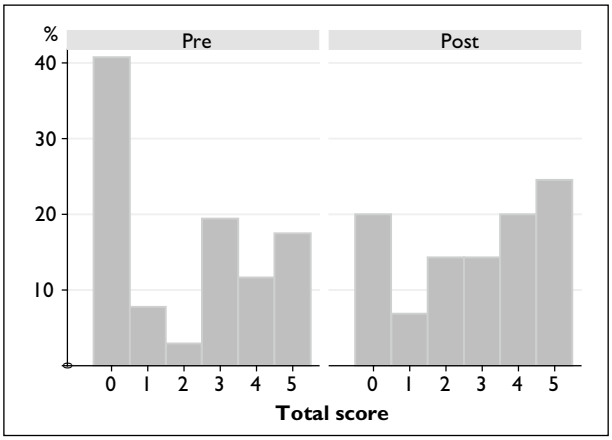

FIGURE 1 Scores as achieved by percentage of cohort – pre- and post-intervention (maximum score achievable was 5).

These findings are compatible with an improvement in performance following exposure to the CAL package. We propose that future evaluations of CAL should aim to incorporate similar performance measures in their validation process.

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[4]Professor of the Medicine of Older People, University of Nottingham

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