Letters to the Editor

THE DIAGNOSTIC AND THERAPEUTIC APPROACH TO PULMONARY VENOUS THROMBOEMBOLISM

Sir, An important outcome from maximising the diagnostic potential of modalities such as spiral computerised axial tomography and nuclear magnetic resonance imaging, cited in the excellent review by Tapson,[1] would be their use as the 'gold standard', in place of invasive procedures such as pulmonary angiography, especially for the purpose of establishing revised diagnostic criteria for the ventilation/perfusion lung scan in the problematic context of the occurrence of pulmonary embolism (PE) in patients with pre-existing pulmonary disorders such as chronic obstructive airways disease (COAD), which can themselves cause defects in perfusion as well as ventilation.[2] Compounding the diagnostic difficulties in this arena is the fact that some of the presenting features of PE, such as increasing breathlessness and even wheezing itself,[3] can simulate exacerbations of COAD, thereby undermining the use of strategies such as clinical index of suspicion i.e. prior probability as adjuncts to the diagnostic process.[4] A complicating factor is that the scan readings that clinicians rely on most heavily for non-invasive diagnosis of PE, namely, high probability and near normal/normal readings, are dramatically reduced in COAD cases with suspected PE relative to patients who do not have pre-existing lung disease, creating greater reliance on pulmonary angiography for diagnostic confirmation.[5] Underscoring the urgent need for resolution of these issues is the fact that, relative to their counterparts without pre-existing lung disease, patients with COPD have a higher mortality risk from PE.[6] Problem areas in the management of confirmed pulmonary embolism include redefinition of the indications for insertion of inferior vena cava filters, given the fact that the significant ($p=0.03$) reduction in embolic risk in the short term may well be outweighed by the significant ($p=0.02$) >2 year increase in the risk of recurrence of lower limb deep vein thrombosis, with concurrent 1-2 year embolic risk no different from that documented in patients managed without this device.[7] The analysis of the >1 year risk/benefit profile of inferior vena cava filtration is further complicated by the recognition that, in the presence of anticoagulant therapy, late i.e. >3 months recurrences of pulmonary embolism are seldom fatal,[8] thereby limiting the justification for long term inferior vena cava filtration to highly individualised indications, applicable to very few patients.[9]

OMP Jolobe
Tameside General Hospital, Ashton under Lyne

REFERENCES

1 Tapson VF. The diagnostic and therapeutic approach to acute venous thromboembolism. *Proc R Coll Physicians Edinb* 1998; 28:173-86.
2 Gilday DL, James AE. Lung scan patterns in pulmonary embolism versus those in congestive heart failure and emphysema *American Journal of Roentgenology, Radium Therapy, and Nuclear Medicine* 1972; 115:739-49.
3 Hatch RT, Parker JM, Engler RJM. Wheezing, hypoxia, and dyspnoea in a 62-year old woman. *Ann Allergy* 1993; 70:363-7.
4 The PIOPED Investigators. The value of the Ventilation/Perfusion scan in acute pulmonary embolism. *J Am Med Assoc* 1990; 263:2753-59.
5 Lesser BA, Leeper KV, Stein PD *et al*. The diagnosis of acute pulmonary embolism in patients with chronic obstructive pulmonary disease. *Chest* 1992; 102:17-22.
6 Carson JL, Terrin ML, Duff A, Kelley MA. Pulmonary embolism and mortality in patients with COPD. *Chest* 1996; 110:1212-9.

[7] Decousus H, Leizorovicz A Parent F *et al* for the Prevention du Risque d'Embolie Pulmonaire par Interruption Cave Study Group. A clinical trial of venal caval filters in the prevention of pulmonary embolism in patients with proximal deep-vein thrombosis. *N Engl J Med* 1998; 338:409-15.
[8] Douketis JD, Kearon C, Bates S *et al*. Risk of fatal pulmonary embolism in patients with treated venous thromboembolism.
[9] Lagattolla NRF, Irvine A, Burnand KG, Ferrar D. Twelve years experience of vena cava filtration. *Ann Royal Coll Surg Eng* 1994; 76:336-9.

'...BUT OUR PATROLS ARE OUT': MEDICAL AND MILITARY BRINKMANSHIP AT THE NORMANDY BRIDGEHEAD AND A ROYAL RESCUE

Sir, In John Forfar's paper in the April *Proceeding* he mentions the one VC won by the R.A.M.C. in the Second World War.[1] I felt that your readers might be interested to know how this was won. I have therefore written a brief account of this.

In January '45 1st Commando Brigade were, for a time, under the command of the 7th Armoured Division in South West Holland. On 23rd January, 6 Commando and 45 (R.M.) Commando were given the task of clearing the Germans from three villages close to a bend in the River Maas. At 8.30 a.m., 6 Commando moved off. The morning was bright and cold and the ground snow covered. The first village was deserted; 45 (R.M.) commando moved through. The second village was searched and also found to be deserted - the enemy had pulled out the night before. With A troop in the lead, supported by a machine gun section of the heavy weapons troop, 45 moved out into flat, open country. Once clear of the villages A troop came under intense machine gun fire from a windmill on their left. The men scattered, the forward section rushing and clearing a farm ahead, while the main body of the troop sought shelter in another farm on their right. Three men were severely wounded, falling in the snow in the open ground. Realising their situation, Lance-Corporal Harden, the troop medical orderly, who had reached the safety of the farm on the right, went out under fire to examine and dress their wounds. He carried one marine back to the safety of the farm buildings, zig zagging all the time as bullets were striking the ground around him. He was slightly wounded and had several bullet holes in his uniform and webbing. The troop commander ordered him not to go out again, but knowing that the wounded men's chance of survival was slight if left lying in the snow, he went out again with two volunteer stretcher bearers to bring in a second man.

Unfortunately, this marine was hit again while on the stretcher and did not survive. With his two volunteers, Harden went out for a third time. On the way back, with about 50 yards to go, he was hit by a bullet on the back of his head and was killed instantly. The troop sergeant major rushed out and carried Harden back while the two stretcher bearers succeeded in carrying the wounded man to safety.

J Tulloch
Woodvale, Edzell, Angus DD9 7TF

REFERENCES

[1] Forfar JO. '...But our patrols are out': medical and military brinkmanship at the Normandy bridgehead and a royal rescue. *Proc R Coll Physicians Edinb* 1998; 28:229-45.

TO BAN OR NOT TO BAN? - THAT IS THE QUESTION

Sir, The editorial in the April issue on the use and misuse of cannabis makes no mention of experience in India. From 1940 to 1946 I served in the Indian army and was well aware that many sepoys took bhang and other preparations of cannabis regularly. Yet I never had a patient whose illness could be attributed to ether acute or chronic misuse of the drug; nor did I hear of any sepoy who had been up before his commanding officer for a misdemeanour attributable to an excessive dose. Any RAMC officer serving in India with British troops would have had ample experience of both sickness and misdemeanour attributable to the misuse of alcohol. One may conclude that cannabis is a less dangerous drug than alcohol.

The editorial says nothing about the benefits of cannabis. I have been told that in an appropriate dose it cheers one up and helps one to relax, but I have no personal experience. Cannabis was not around when I was a student and I do not know now how to obtain it. If any Collegiate Member, especially one whose home is in the East, would bring an appropriate dose to my house at 6.00 p.m. one evening, I should be delighted. In return he or she would be given a dose of my regular medicine, a tot of malt whisky. Then we could enjoy a discussion of the important issues raised in the editorial. Before coming please ring 0130 447 0569.

R Passmore
54 Newbattle Terrace, Edinburgh

ETHICAL ISSUES FACING THE PRACTISING GERIATRICIAN[1]

Sir, The impact of some of the ethical dilemmas in the care of the older patient can, in some measure be neutralised by identifying, and acting on modifiable risk factors for age-related disability. Relevant to this issue are two recent publications, one dealing with postponement of disability,[2] and the other with risk factors for five-year mortality.[3] The first study showed that long-term physical disability could be predicted through documentation of three modifiable risk actors, namely, smoking habits, physical activity, and body mass index (disability index being twice as high in the high risk group as in the low risk group; $p<0.001$), and these parameters (with due adjustment for the J-shaped curve of the mortality risk attributable to body mass index) also predicted five-year mortality risk for older subjects in the second study. Increasingly, therefore, promotion of healthy lifestyles should become part of the geriatric package of healthcare, and we should be in the vanguard of propagating this message in our educational encounters with general practitioners.

OMP Jolobe
Tameside General Hospital, Ashton under Lyne

REFERENCES

1 Banerjee AK. Ethical dilemmas facing the practising geriatrician. *Proc R Coll Physicians Edinb* 1998; 28:4-14.

2 Vita AJ, Terry RB, Hubert HB, Fries JF. Aging, health risks, and cumulative disability. *N Eng J Med* 1998; 338:1035-41.

3 Fried LP, Kronmal RA, Newman AB *et al* for the Cardivascular Health Study Collaborative Research Group. Risk factors for 5-year mortality in older adults. *J Am Med Assoc* 1998; 279:585-92.

FELLOWSHIP AND MEMBERSHIP SURVEY: THE ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

Sir, I write as editor of *Chiron* to express my surprise, profound distress, diappointment, and alarm at the fact that in a College Report about 7% of Fellows and Members ranked *Chiron* as the most preferred College publication[1] compared with 40-50% each for *Proceedings* and *Current Medicine*. I was even more surprised to read that, because of this result 'improvement is required to increase its appeal to readers.' Surely the aims of *Proceedings* (and *Current Medicine*) and *Chiron* are totally different. Although non-parametric entities can be ranked in order of preference other judgements can rarely be drawn.

The reason for my surprise, profound distress, disappointment etc. Is that, in an institution with scientific ethos, the preference for *Chiron* was not zero! I was simultaneously encouraged that a publication of only 12 pages is preferred by 7% of Fellows and Members. Give *Chiron* an equal playing field of 170 pages (less than the average number of pages in *Proceedings*).... but I digress.

The authors of the Report have made a common error. It is illogical to compare chalk with cheese, to find that most people prefer chalk, and to go on to form a judgement that cheese should be improved. Even poets do not allow themselves to compare non-parametric entities. 'Shall I compare thee to a summer's day?' was found to be an impossible comparison by Shakespeare because 'thy eternal summer shall not fade'.[2]

If, for the sake of discussion, we accept that non-parametric entities are to be compared, and judgements made, then logically, to achieve the desired 100% preference for publications other than *Chiron*, it is necessary for *Chiron* to be worsened (the opposite of what was suggested in the report) or the other publications improved.

Finally, in the questionnaire on which the Report was based, I put *Chiron* last, as should be the case and yes, *Chiron* like everything else, can be improved.

I am, Sir, writing on behalf of *Chiron* who as you may be aware had connections in high places by virtue of being the guardian of Aesclepius, a Greek God. The Roman associates of Aesclepius suggested that I write this *fulmen brutum*.

PD Welsby
City Hospital, Edinburgh

REFERENCES

[1] Jones A, Lewis S, Agius R, Doyle D, Lawson D. Fellowship and Membership survey: the Royal College of Physicians of Edinburgh. *Proc R Coll Physicians Edinb* 1998; 28:273-86.
[2] Shakespeare. Sonnet 18.