Appraisal of self-learning
Sir,
May I through your columns ask your readers for information about appraisal of self-learning? As a general practitioner tutor I am well aware that individuals have different learning styles and motivations. I therefore feel that a good part of my task is to ensure that my registrar (trainee) develops the necessary skills and motivation for future self-learning. Though most of my 'training' is now demand-led I wish to develop skills to monitor the development of self-education in my registrar. Can colleagues direct me to relevant papers and medline fields?

MB TAYLOR
Baatem Centre for Postgraduate Medical Studies, Birch Hill Hospital, Rochdale, Lancs OL12 9QB, UK

Prevalence of diabetes in elderly patients with pacemakers
Sir,
Smith et al, have discussed coronary heart disease, valvular heart disease, bradycardia and heart failure in the elderly patient.1 In one study, 82% of pacemaker implants were in patients aged over 65 years.2 Indications include syncope associated with complete heart block or sinus arrest, symptomatic sick sinus syndrome and symptomatic incomplete atrioventricular block. More debatable is the choice of pacemaker.3 Pacemakers are a major risk factor for the development of coronary heart disease.4 Diabetics have increased rates of heart block following a myocardial infarction5 and right bundle branch block is more common in the diabetic outpatient population.6 We have assessed whether diabetics aged over 65 are more likely to need permanent cardiac pacemaker insertion. Patients who had undergone permanent pacemaker insertion were identified using hospital activity analysis data and ward admission books and case notes. Data for the reference population was obtained from a previous survey.7 A total of 942 patients were identified, of whom 11.07% were diabetic. In our control group 8.25% were diabetic. This gave a relative risk of 1.34 (p < 0.01), 95% confidence interval 1.25–1.44.

This result is an underestimate of the true relative risk for two reasons: the hospital activity analysis coding for diabetes is not 100% complete and so patients with diabetes were missed. Also, the non-diabetic group undergoing pacing are an unscreened group and it would be expected that some of them will be undiagnosed diabetics. It has been shown that the prevalence of elderly undiagnosed diabetics in the community is 3.3%.8 Therefore, although it has been suggested that there is a microangiopathic effect,9 it has also been shown in experimental diabetic animals that there is increased cholinergic sensitivity10 and this may have an effect on cardiac conduction. The aetiology is likely to be multifactorial and more research is needed to establish the relative contributions of these factors.

JT LEAR
IG LAWRENCE
AC BURDEN
Department of Medicine, Leicester General Hospital, Gwendolen Road, Leicester LE5 4PW, UK

Summary/learning points
- 8–11% of patients undergoing permanent pacemaker insertion may be diabetic

Glucose-6-phosphate dehydrogenase deficiency
Sir,
We read the recent excellent review of glucose-6-phosphate dehydrogenase (G-6-PD) deficiency by Mehta1 with great interest. Based on experience in Israel, we do not, however, concur with his statement that 'Kernicterus has been described in all population groups'. While G-6-PD deficiency is prevalent among some subsets of Sephardic Jews, neonatal jaundice associated with the condition in this population is milder than that observed in some other countries. In the early 1960s, before the advent of phototherapy, and at the same point in time as reports of kernicterus emanated from Greece, Zeinberg et al were unable to document any cases of kernicterus attributable to this condition. Two subsequent studies3,10 demonstrated a high incidence of neonatal jaundice in G-6-PD-deficient neonates, but with a low rate of kernicterus. Mitochondrial abnormalities were encountered in either of these studies. The overwhelming majority of our cases respond to phototherapy, which we commence when serum bilirubin levels exceed 250 μmol/l.

Clearly, in different population groups, environmental or genetic factors appear to interact with G-6-PD deficiency to either dampen or exacerbate the jaundice. Sephardic Jewish G-6-PD deficient neonates appear to be at an advantage in this respect, over their counterparts in other ethnic groups.

MICHAEL KAPLAN
CATHY HAMMERMANN
Department of Neonatology, Shaare Zedek Medical Center and Hadassah Medical School of the Hebrew University, Jerusalem, Israel


Gallstone ileus: an old role for abdominal ‘hand’ scanning
Sir,
I was surprised that the 69-year-old patient reported by Seal and colleagues1 spent 14 days undergoing investigations before eventual surgery for gallstone ileus, and was in hospital for all of 10 weeks. Her extensive investigation included abdominal ultrasonography, double contrast barium enema, retrograde endoscopy and isotope bone scintigraphy before an abdominal computer tomography (CT) scan yielded the correct diagnosis. Although this makes an interesting case report it illustrates how excessive reliance on investigations may sometimes fail to advance the diagnosis, incur needless costs, prolong hospital stay and delay definitive treatment. The diagnosis could have been made earlier by the timely application of the ‘hand’ scan.

Features of small bowel obstruction associated with a palpable mass in the right iliac fossa in an elderly patient with anaemia and right iliac fossa pain is a common dilemma. The laparotomy as soon as the patient is deemed fit for surgery. Further investigation is unlikely
to contribute significantly, and will not alter the need for surgery. Laparotomy in this case would have been both diagnostic and therapeutic. Even in this technological age, we should not forget that the old fashioned 'hand' scan at laparotomy can be an appropriate early investigation.

R HUTCHINSON
Good Hope Hospital,
Rectory Road, Sutton Coldfield,
West Midlands B75 7RR, UK


The changing context of undergraduate medical education

Sir,

Working in a district general hospital linked to a teaching hospital we have a constant turnover of clinical medical students attached to our unit. We were therefore interested in the article by Parsell and Bligh1 discussing possible approaches to undergraduate education. They suggested a core curriculum with less factual information than the present system and more problem-based learning. In our experience, the latter has been a part of ward-based clinical teaching for some time but requires an adequate background knowledge to be effective.

At the end of their attachment to our unit each student is examined. This involves clinical cases and a separate 'spot' exam consisting of electrocardiograms (ECGs), X-rays and data interpretation. We recently analysed the last six months exams from 40 junior (3rd year) and 15 senior (4th or 5th year) students. In the ECG section 85% correctly recognised an acute myocardial infarction, 76% correctly stated whether the axis was left, right or normal, 76% correctly described the rhythm (sinus) and 51% were able to calculate the heart rate.

We are all able to remember facts drummed into us at medical school which are of no relevance to the practice of clinical medicine and strongly support the efforts of those trying to improve the undergraduate education process. The differences found between our students’ abilities to recognise an acute myocardial infarction and to calculate heart rate suggests more emphasis needs to be placed on the core knowledge which we all try to work upon. Rather than adding to such a syllabus the problem will be what to leave out. The use of an objective, structured, clinical examination would seem a sensible way of ensuring an adequate core knowledge as well as more detailed problem-based knowledge. If not, pattern recognition of a myocardial infarction but no concept of other variations may become the norm.

K SHOTLIFFE
A BLIGHT
V SAXENA
Diabetes Centre,
St Helier Hospital,
Wrythe Lane,
Carshalton, Surrey, UK