PostScript

LETTERS

Cost effective strategy to risk stratify acute chest pain cases at a district general hospital

I read with interest the paper by Miller *et al.*¹ The “high risk” patients with acute coronary syndrome are kept in hospital these days for a possible early intervention. This is in line with the FRICS-II recommendations.

One of the fundamental principles of the National Service Framework (NSF) for coronary heart disease is to reduce the inequality in the provision of cardiac services across the UK. Miller *et al.* showed that patients admitted to a district general hospital with acute coronary syndrome are at a disadvantage in terms of access to interventions, compared with patients with the same condition admitted to a hospital with a tertiary centre on-site.¹

I agree with the authors that equity of access could be achieved by establishing independent function for an invasive facility so that the tertiary centres can serve in a more uniform manner.

A number of patients admitted to a district general hospital with acute coronary syndrome are not referred at all. The reluctance is partly due to the difficulties in referring patients in time for interventions, and partly due to the fact that the pressure of beds remains high at all times. District general hospitals follow a stringent protocol to “fast track” only the high risk patients.

Innovative action plans, such as the introduction of chest pain observation units (CPOUs) suggested by Goodacre *et al.*,² seem like a cost effective way for evaluating patients with undifferentiated chest pain. In a survey of 238 British hospitals, however, CPOUs were present only in 38 (21%).³ CPOUs in the United States attempt to improve the diagnostic accuracy of acute coronary syndrome. Patients are subjected to a battery of tests. If all the tests are negative the patient is sent home and if the tests are positive or equivocal they are referred for further investigations.

In the UK, with much less interventional radiology and higher discharge rates from emergency departments, such a policy may appear to be a non-starter. On the contrary, it is worrying to note that in the UK 6% of patients discharged from emergency departments after attendance with acute chest pain were found to have prognostically significant myocardial damage.⁴

To achieve the NSF goal of removing any inequality of coronary heart disease services, district general hospitals may have to formalise a uniform guideline so that they can risk stratify the cases of chest pain effectively in a CPOU.^{2,3} They should aim to risk stratify the cases of acute coronary syndrome as per Braunwald's classification.³ They will then be able to “fast track” the highest of the high risk patients and thereby reduce congestion at the tertiary centres.

In the ROMEO rule out trial it was evident that it was feasible to provide consistent care for people with acute chest pain who presented to emergency departments in the UK.⁵ It is to be hoped that more UK hospitals adopt

such a policy to reduce congestion at tertiary centres. This may also help remove the inequality that is present in UK hospitals so far as the management of acute coronary syndrome is concerned.

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- 2 Goodacre S, Morris F, Arnold J, *et al.* Is a chest pain observation unit likely to be cost saving in a British hospital? *Emerg Med J* 2001;18:11–14.
- 3 Sinharay R. Diagnostic guidelines for acute coronary syndrome in British hospitals—a feasible and cost effective strategy? *Br J Cardiol* 2003;10:193–4.
- 4 Collinson PO, Premchandran S, Hashemi K. Prospective audit of the incidence of prognostically important myocardial damage in patients discharged from emergency department. *BMJ* 2000;320:1702–5.
- 5 Taylor C, Forrest-Hay A, Keeks S. ROMEO; a rapid rule out strategy for low risk chest pain. Does it work in a UK emergency department? *Emerg Med J* 2002;19:395–9.

Bacillus anthracis diversity in the Far East of Russia

Though anthrax has been a cause of death in Russia, especially in regions with highly developed cattle breeding, the Russian Far East has not been considered an area with a high morbidity from the disease. But this region has a recorded history of periodic anthrax epidemics causing widespread disease among wild and domestic animals.

The first inhabitants appeared in the Far East of Russia at the end of the 19th century. The first outbreak of anthrax was recorded in 1904 in Primorski (the southern part of the Russian Far East) when 30 people died from this disease in two weeks. In 1919 only one case of the disease was recorded but then, periodically, new cases were recorded every five years.¹ The first cases of anthrax at the

beginning of the 20th century were found in those working in industries connected with cattle, and especially in the tanneries of the first colonists.

The largest outbreak of anthrax was recorded in the territory in the 1930s,² and there was a 16.6% morbidity for all patients with diagnosed anthrax. In 1977, 15 cases of anthrax were recorded with one lethal case in each of three villages located distantly from each other. In 1979, 12 cases were recorded and two people died; some more cases of anthrax were recorded, but there were no deaths. All patients had the pulmonary form of anthrax with severe clinical symptoms despite effective and adequate treatment.

From 1930 cases of anthrax in domestic and wild animals have been recorded (see fig 1). Anthrax is associated with special soil conditions such as having a humus content of more than 1% (from 2%–4%), with the humus layer more than 0.15–0.3 metres, pH 4–7, and high moisture even in the dry months (usually August or September).

So, despite the worldwide threat of anthrax bioterrorism, anthrax should also be investigated at the local level. It is necessary to improve recording of such a dangerous infection, and only strict public health policy can prevent its spread throughout the world.

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References

- 1 Rosenberg NK. *Infectious diseases and epidemiology*. 4th Ed. Leningrad: MedGiz, 1938: 752.
- 2 Zelepukin VS. *Anthrax in different regions of Russia*. Reports of Temiryazev Agricultural Academy Report, 1973: 191.

Figure 1 Number of cases of anthrax in domestic and wild animals in the Primorski Region, 1930–81.

Roth's spots: righting a historical wrong

A recent case report described "Roth's spots" as an unusual presentation of HIV.¹ Unfortunately, white centred retinal haemorrhages have popularly come to be known as Roth's spots despite the fact that Roth never described such lesions. According to Sapira, who reviewed the original German manuscripts,² Roth described both retinal red spots (which were first described by Bowman) as well as retinal white spots in patients with septic retinitis. He never described white centred haemorrhages, which were first described by Litten in 1978, six years later. While I am not advocating that the eponym change to "Litten's spots" it seems to me that historical accuracy is important if only to give credit where it is due.

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- 1 Vose MJ, Charles SJ. Roth's spots: an unusual presentation of HIV. *Postgrad Med J* 2003;79:119.
- 2 Orient JM. *Sapira's art and science of bedside diagnosis*. 2nd Ed. Philadelphia: Lippincott Williams and Wilkins, 2000.

BOOK REVIEWS

The reviewers have been asked to rate these books in terms of four items: readability, how up to date they are, accuracy and reliability, and value for money, using simple four point scales. From their opinions we have derived an overall "star" rating: * = poor, ** = reasonable, *** = good, **** = excellent.

Get Through Medical School: 1000 SBAs/BOFs and MEQs

Una Coales and Seema Khan. (Pp 287; £19.95.) Royal Society of Medicine Press, 2002. ISBN 1-85315-546-2.***

The title of this book says a lot about some attitudes to medical education. It is unlikely that one could get through medical school by being able to pass 1000 or even 10 000 single best answer/best of five and extended matching questions. Nevertheless these types of questions are being used more frequently in medical schools since they are in general better tests of knowledge in context than the more traditional multiple choice question paper.

The questions cover a broad range of common topics with those from general medicine and surgery predominating and are generally well constructed with only a few inaccuracies. The emphasis is on the final examination.

The origins of the questions are not clear. Did the authors construct them all themselves? Have they been tried out in practice? Even highly experienced question setters will know how sometimes their best efforts fail the comprehension test when tried out for real. Some knowledge of their track record would be reassuring.

The answers appear as a block at the end of each chapter. This makes rapid checking difficult. A system of page referencing would improve this.

Overall this will be a helpful book for students preparing for finals.

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Review of ABC of Clinical Haematology.

Edited by Drew Provan. (Pp 88; £17.95.) BMJ Books, 2002. ISBN 0-7279-1676-9.***

Clinical haematology is a subject which impacts directly across the entire spectrum of clinical medicine and has implications for all medical and allied professions. Consequently it is important that there is an introductory text, which can encapsulate both the basics and recent advances in an easily digestible format. Such a text should be concise, to the point, and easy to read. To a large extent *ABC of Clinical Haematology* succeeds in all these areas, and can be recommended as an introductory text suitable for most practitioners. Drew Provan has assembled a range of senior haematologists who have contributed to an update of the original text. The book is well laid out taking advantage of good illustration, tables and figures making the contents easy to assimilate. The chapters cover all relevant areas of clinical haematology including anaemias, acute and chronic leukaemias, the lymphomas, and coagulation abnormalities. The chapter on haematological emergencies will be particularly useful for generalists and the chapter on the future of haematology introduces general conceptual advances coming into the clinical arena.

The layout of the book is good and the level of information presented is adequate for the introductory text it sets out to be. It is, however, far from comprehensive and more in-depth information will need to be obtained from other sources. The list of references at the end of each section provides a ready starting point for this process. Most of the chapters are consistent with current practices and describe the clinical approach to the investigation and management of these conditions. Rather disappointingly the chapter on Hodgkin's disease and the lymphomas has not really been updated to take into account the concepts implicit in the REAL and WHO classifications, which are now in widespread use. Despite this criticism this is a useful text, which provides an excellent introduction to the subject and will be widely useful for all professions involved with patient care.

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Advanced Surgical Practice.

Edited by A A Majid and A Kingsnorth. (Pp 862; £95.) Greenwich Medical Media, 2003. ISBN 1-84110-018-8.***

The explosion in information technology was initially predicted to eliminate the need for textbooks and journals. Thankfully this has not occurred and opinion is beginning to revert to common sense with teaching aids complementing, rather than competing. *Advanced Surgical Practice* is a comprehensive major surgical textbook edited by two eminent surgeons and is undoubtedly of value to higher surgical trainees who wish to have a knowledge of "general surgery" in its broadest sense. However, I fear that "advanced" is inaccurate when applied to many of the topics covered. The many contributors have adopted somewhat different styles, a common feature of all multi-author texts. Some of the detail goes beyond what one would expect, for

example there is far too much on biliary atresia. Some important topics are left out, there is little on hernia except paediatric and the laparoscopic approach. Some sections do not allow for individual opinions, the section on small bowel anastomoses recommends a polypropylene double ended continuous suture, without specifically stating that practically any suture, and any technique (interrupted or continuous), will work in most cases. My laparoscopic colleagues inform me that the technique recommended for appendectomy may be unsafe as it leaves a long stump and leaves a potential for stump abscess formation. In my own field of colorectal cancer the suggestion that a rectal tumour has to be more than 7 cm from the anal verge to allow anterior resection is outdated.

Nevertheless this book is a useful reference and should be available to all higher surgical trainees, though perhaps not everyone needs to own one.

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Advanced Examination Techniques in Orthopaedics.

Edited by Nick Harris and David Stanley. (Pp 229; £35.) Greenwich Medical Media, 2003. ISBN 1-84110-073-0.***

Examination of the musculoskeletal system is an important part of many clinicians' daily practice. The aim of this book is to bring together the advanced techniques of examination of the components of the musculoskeletal system and it achieves this. The target audience is postgraduates undertaking examinations in orthopaedics but it has a wider appeal and should be read by all involved in postgraduate and undergraduate teaching, physiotherapists and rheumatologists, and specialist general practitioners.

It is a book that will appeal visually to most orthopaedic specialists. The many colour illustrations demonstrate normal anatomy. Certain physical signs are best demonstrated with examples and there is a paucity of positive examples except in the chapters relating to children's conditions. Overlap between different authors is generally avoided but not altogether. The grading of muscle power is given in examination of the hand and examination of the brachial plexus, it is almost identical in both tables, but attributed to different sources, which could confuse exam candidates. Certain parts of the body are more amenable to comprehensive cover, and are well done, such as that of examination of the shoulder. The overall style is of necessity didactic. Areas of contention or controversy are hinted at in the chapter on examination of the spine but not expanded upon.

This is a book I would recommend as a useful addition to all postgraduate libraries and it should be on the reading list of all postgraduates taking examinations involving the musculoskeletal system.

P Sell

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Problems in Pediatric Drug Therapy. 4th Ed.

Edited by Louis A Pagliaro and Ann Marie Pagliaro. (Pp 829; \$99.) American Pharmaceutical Association, 2002. ISBN 1-58212-001-3. ****

This textbook is well written and is easy to follow. It is a comprehensive text regarding paediatric prescribing including sections on drug administration, drugs as human teratogens, and gives good advice regarding drug excreted in breast milk. There are comprehensive sections regarding adverse drug reactions and paediatric poisoning and two large separate sections regarding drug dosing in neonates and separately for infants, children, and adolescents.

There are additional useful chapters regarding abuseable psychotropic use among children and also a comprehensive chapter regarding paediatric immunisations.

This textbook will be of principle use to pharmacists working in the paediatric and maternity field and in addition is a useful textbook to have available in any paediatric and neonatal department to inform safe and improved prescribing.

The book is reasonably priced at \$99. It is comprehensively referenced and, thus, evidence based.

A C Elias-Jones

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Managing Change for Effective Clinical Practice.

Trisha Greenhalgh, Moria Sarsfield, and Peter Toon. (CD ROM; personal rate: £50+ VAT, any 2 CDS £75+VAT; institutional rate: £75+VAT, any 2 CDS £150+VAT.) BMJ Publishing Group, 2002. ISBN 0-7279-1706-4. ****

This CD Rom aims to be the beginners' guide to managing clinical change. It tackles important areas of day-to-day clinical practice. At the same time it allows the clinician to overview the bigger picture, particularly using SWOT and PEST analysis, for example. These acronyms, while initially unhelpful, have become standard medical jargon from the perspective of medical managers.

On using this CD many clinicians will be able to understand the terms and language used by their management colleagues. At the very least this CD will allow readers to contemplate their current clinical systems. However, if used currently this CD will also be an important starting place from which to improve management practices and make them more effective, particularly with larger institutions.

J Jankowski

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Incontinence in Women.

Edited by A B Maclean and L Cardozo. (Pp 458; £48, £36 to fellows and members of the RCOG.) Royal College of Obstetricians and Gynaecologists Press, 2002. ISBN 1-900364-67-0. ****

The Royal College of Obstetricians and Gynaecologists have convened study groups to address important growth areas within the

specialty. This volume has resulted from the collective opinions of an eminent international group.

The editors can be congratulated on achieving the objectives and providing an interesting as well as easy to read essential addition to every obstetrician and gynaecologist's personal library. This is of particular note when the practice of the specialty is becoming more subspecialised.

Even the practitioner with an entirely obstetric based practice would find this book of interest. The chapter on prophylactic caesarean section is a particularly enjoyable and stimulating addition to a debate that focuses both lay and obstetricians' minds. The suggestion of physiotherapists educating midwives in the management of the pelvic floor will lead to radical local discussion on the place of an integrated team approach to health care delivery.

For the trainee and MRCOG candidate this book is a must; it contains the experience of experts beautifully presented at a depth which will not only be adequate for their training but qualified by discussion from some of the most acclaimed opinions.

The book conveys sound common sense in the broadest of areas; risk management of the ureteric injury is dependent on the wording of the operative note as much as surgical skills when a successful defence is concerned. It is a sad reflection on the NHS to note experts contributing to the discussion commenting on inadequate surgical exposure secondary to the wrong operative facility being accessible. The current trend to a more litigious society will not be reversed but at least will be contained when experts state their case in a clear clear fashion.

The repair of the anal sphincter and anal incontinence are explored. The diagrammatic illustration is a reminder that a pictorial representation of the tears is a useful adjunct to audit. Faecal incontinence has been a Cinderella subject in the specialty for too long; it is a worthy addition to the specialty to see that this book includes opinion on such.

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Paediatric Vade-Mecum. 14th Ed.

Edited by T G Barrett, A D Lander, and V Diwakar. (Pp 589; £19.99.) Arnold Publishers, 2002. ISBN 0-340-80673-7. ****

What is the need for this book? The aspiration is for a portable, easy access, reliable guide. Most departments nowadays have sets of guidelines, access to drug formularies, online computers, and better junior doctor support which lessen the need. The almost 600 pages in smallish print would fit in a handbag but would create an unsightly bulge in conventional clothing. The palmtop version is a great idea but I was unable to access the website to download it.

The index is a key feature and is pretty comprehensive (a few omissions) and the cross referencing was good. The style is didactic (although variable from section to section) and informative without being overcomplicated.

In general the book is better on management than diagnosis and a symptom based approach rather than systems based would be an advantage but much more difficult to edit. There were one or two other gripes such as

exhortations to full history and examination rather than key features, and it is rather sad to see that general paediatrics is reduced to Bell's palsy, ear, nose and throat problems, reflux, rashes, and urinary tract infections.

The formulary was fairly comprehensive and the section on normal values is useful. I also liked the "thumbnails" for those myriad childhood syndromes that turn up in clinic to test your knowledge of middle European surnames. This could be expanded as even with >300 entries, a lot were missing.

References are almost non-existent but essential as a basis for drawing up local guidelines or to direct further reading.

There are good ideas and sound clinical advice within the pages but the trainees I spoke to felt no great need to purchase.

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Heart Failure in Practice.

B S P Chin, M K Davies, and G Y H Lip. (Pp 76; £14.95.) Royal Society of Medicine Press, 2002. ISBN 1-85315-487-3. ****

Heart failure currently accounts for 5% of all medical admissions. All clinicians, irrespective of their specialty, will come into contact with patients with heart failure at some point in their career. There have been many advances in the treatment of heart failure and it is important for clinicians not only to be aware of these, but also to translate them into their clinical practice.

This book by Chin, Davies, and Lip is 76 pages long and covers in a logical fashion different aspects of heart failure starting from its aetiology right through to its management. It is easy to read and covers all the important studies. It is extremely well laid out with numerous diagrams including x-rays, ECGs, colour flow Dopplers, and echocardiograms. Whenever possible, the authors have taken care to summarise information into tables or boxes to make it easier for the reader to follow. The authors also provide a list of acronyms, a fashion started by cardiologists, and appendices covering guidelines for the management of heart failure in primary and secondary care. On the inside cover is a very useful diagnostic flow chart.

The layout of the book, the style of writing, and the accurate and up-to-date nature of the information contained within it make this an essential book to have on personal bookshelves, particularly for all doctors, junior and senior, involved in the care of patients with heart failure. In addition, the book would serve as an excellent primer for the increasing number of heart failure specialist nurses.

M Pirmohamed

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Neurophysiology.

R H S Carpenter. (Pp 466; £24.99.) Arnold Publishers, 2003. ISBN 0-340-80872-1. ****

This is a good book.

The first section deals with the general neural mechanisms which underlie the function of the nervous system and then sensory, motor, and higher functions are explored in the subsequent three sections in which

individual chapters cover topics such as vision, control of posture, motivation, and control of behaviour.

The book does not merely convey factual information but seeks to promote understanding of the principles and concepts which underpin neurological function. In so doing it allows the reader insight into some of the pioneering experimental research which led to the current state of knowledge. The author's enthusiasm for his subject is apparent in the carefully written text which is supplemented by plentiful clear line drawings and boxes of tables with systematic information. The accompanying useful CD-ROM includes NeuroLab interactive simulations, an atlas of neuroanatomy, and some clinical applications which help to integrate the basic neurophysiology with actual neurological function. There are references and guides to further reading at the end of each chapter with short biographical notes of some key figures who have made major contributions to the understanding of neurophysiology.

This book, which is attractively produced, should be read by all serious students of physiology. It should be available in all self-respecting university and medical school libraries and the price of the paperback version places it within the reach of the student who wishes to have a personal copy.

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UK

BOOKS RECEIVED

The receipt of these books is acknowledged and this listing must be regarded as sufficient return for the courtesy of the sender. Books that appear to be of particular interest will be reviewed space permitted. The journal does not publish unsolicited reviews.

A Clinical Guide to Epileptic Syndromes and their Treatment.

C P Panayiotopoulos. (Pp 278; £39.95.) Bladon Medical Publishing Limited, October 2002. ISBN 1-904218-23-7.

Managing Obstetric Emergencies and Trauma—The MOET Course Manual.

Richard Johanson, Charles Cox, Kate Grady, and Charlotte Howell. £44.00 (£33.00 to Fellows, Members and Trainees of the RCOG.) RCOG, February 2003. ISBN 1-900364-70-0.

Recent Advances in Obstetrics & Gynaecology 22.

Edited by John Bonnar and William Dunlop. (£35.00.) RSM Press, March 2003. ISBN 1-85315-529-2.

Combination Therapy & Hypertension.

Michael Schachter. (Pp 57; £10.95.) Martin Dunitz Publishers, May 2002. ISBN 1-85317-732-6.

Hypertension in the elderly. 2nd Ed.

Norman M Kaplan. (£10.95.) Martin Dunitz Publishers, June 2002. ISBN 1-84184-187-0.

Problem Orientated Obstetrics & Gynaecology.

Ian Symonds, Philip Baker, and Lucy Kean. (Pp 326; £24.99.) Arnold Publishers Ltd, 2002. ISBN 0-340-75906-2.

Learning Medicine. 16th Ed.

Peter Richards and Simon Stockill. (Pp 160; £15.95.) BMJ Books, 2002. ISBN 0-7279-1712-9.

DIARY

Warwick University Short Courses

8–9 December 2003. An introduction to microarray technology and its applications.

17–18 March 2004. An introduction to immunology.

For details please contact Dr Steve Hicks, Department of Biological Sciences, University of Warwick, Coventry CV4 7AL, UK (tel: +44 (0)2476 523540; fax: +44 (0)2476 523701; email: s.j.hicks@warwick.ac.uk).