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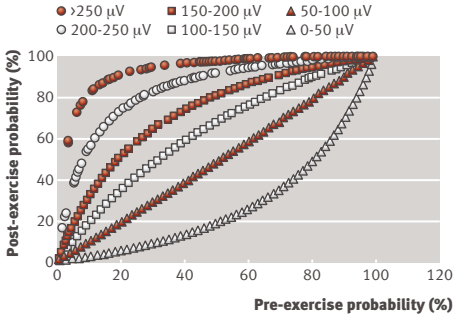
LETTERS

NICE AND CHEST PAIN DIAGNOSIS

Exercise ECG useful in finding coronary artery disease



Impact of exercise-induced ST shift on CAD probability

The National Institute for Health and Clinical Excellence (NICE) uses probability to help diagnose chest pain,[1] but why stop with symptoms?

Since 1999 we have asked everyone attending the rapid access chest pain clinic at this hospital to complete a questionnaire.[2] The probability of coronary artery disease (CAD) is then calculated from this and 12 lead electrocardiography (ECG) before the person is seen.[3] All those undergoing Bruce treadmill exercise testing also have their probability of CAD after exercise calculated by Bayes' theorem: where pre-exercise probability is the prior probability and the sensitivities and specificities are obtained from the maximum shift in ST segment.[4] As NICE's adaptation of Pryor et al[3] excludes 12 lead ECG, I recalculated the probability of CAD before and after exercise of 5369 people (5177 referred direct from primary care) without these data.

The figure shows that the probability of CAD after exercise falls if the maximum ST segment shift is less than 50 µV and increases if the ST shift is more than 100 µV.

NICE recommends that chest pain management differs when thresholds of probability of CAD of 30% and 60% are crossed. Use of the probability of CAD after exercise would have changed the management of 1868 (34.8%) of these people with chest pain: 549 with a pre-exercise probability ›60% and a post-exercise probability ‹60%, 236 with pre-exercise ‹60% and post-exercise ›60%, 1064 with pre-exercise ›30% and post-exercise ‹30%, and 194 with pre-exercise ‹30% and post-exercise ›30% (the probabilities of 175 people crossed both the 30% and the 60% boundaries).

When electrocardiographic information is included in the derivation of pre-exercise probability of CAD, the management of 1915 (35.7%) people is changed after exercise.

These results call into question NICE's recommendation not to use exercise ECG to diagnose or exclude stable angina for people without known CAD.

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Competing interests: None declared.

I thank the members of the ECG team who entered the data into the bespoke database.

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Cite this as: *BMJ* 2010;340:c1971

MEN WHO HAVE SEX WITH MEN

Don't forget local epidemiology and guidance…

Presentation to general practice may be the only opportunity to manage some men who have sex with men,[1] but such patients should be managed in primary care only after attempts to encourage attendance at genitourinary medicine clinics have failed. Such management should also be informed by local epidemiology and current testing guidance.

For example, the prevalence of gonorrhoea in men is about the same in Australia and the United Kingdom (46/100 000), but men who have sex with men account for one third of UK cases (4524/13 627 in 2006). Wong and Fairley do not advise that a urethral swab be taken for gonorrhoea but the British Association for Sexual Health and HIV (BASHH) continues to recommend sampling all mucosal surfaces, including the urethra, in symptomatic males.[2 3]

Wong and Fairley also do not advise testing for hepatitis, in accordance with Australian guidelines but contrary to UK guidelines.[4 5] They advise that human papillomavirus vaccination should be considered in men who have sex with men, depending on the chance of previous infection, but this is not currently endorsed or funded by the NHS.

General practitioners need to be aware that guidance frequently changes in response to local epidemiology and policy and should also feel comfortable in seeking the opinion of specialists in genitourinary medicine.

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Competing interests: None declared.

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…and hepatitis B immunisation

To the list of tasks for the first consultation for men who have sex with men should be added offering a first dose of hepatitis B vaccine in the UK.[1] Hepatitis B vaccination is part of the Australian immunisation schedule[2] but not the UK schedule.[3] Unless a man who has sex with men falls into an occupational or other risk group specifically targeted in the UK for hepatitis B immunisation,[4] he is unlikely to have already been immunised against hepatitis B. Vaccination should also not be delayed while waiting for results of tests for markers of current or past infection.[4]

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;340:c1978

LYMPH NODE TUBERCULOSIS

Time for a culture change?

Sellar and colleagues highlight three patients presenting with lymphadenopathy in whom appropriate management was delayed owing to a presumptive rather than definitive diagnosis of tuberculosis.[1] However, tuberculous lymphadenitis cannot be rapidly diagnosed from the presence of acid- and alcohol-fast bacilli in fine needle aspirates. All mycobacteria are acid- and alcohol-fast on Ziehl-Neelsen staining,[2] and non-tuberculous mycobacteria are an important cause of disease in immunocompetent children and in patients with HIV.[3] Surgical excision is advocated for paediatric non-tuberculous mycobacterial lymphadenitis and medical treatment alone reserved for tuberculous disease.[3]

In many patients with lymphadenopathy the results of fine needle aspiration will be inconclusive and lymph node biopsy will be required. A survey of 5225 lymph node biopsies obtained over five years in Lothian highlighted the prevalence of lymph node culture as less than 30% for nodes with a pathological diagnosis of, or within the differential diagnosis of, mycobacterial lymphadenitis (including granulomatous inflammation, sarcoidosis, acute inflammation, fibrosis). Of the nodes submitted for culture, *Mycobacterium tuberculosis* was identified from half and was cultured from lymph nodes with a pathological diagnosis of "acute inflammation," further confirming the importance of culture of fresh tissue for correct diagnosis. (J R O'Neill at al, South-East Scotland School of Surgery meeting, Edinburgh, October 2007.)

The lesson of the week should be to achieve the correct diagnosis by appropriate investigation, including culture of fresh tissue in patients with unexplained lymphadenopathy, before subjecting them to months of potential toxic treatment.

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Cite this as: *BMJ* 2010;340:c1975

EUROPEAN LOCUMS

Reconsider the locum system

It is difficult for surgical departments around Europe to abide by working time directives, but a solution has not been to bring in unknown locum doctors to fill the gaps.[1] Judging surgical capabilities on the basis of a CV and an interview is difficult, especially if the doctor is from a foreign training system. Such skills can be evaluated only by performing surgery under supervision, which is not possible in the locum system.

The NHS expects locum doctors to fit in immediately and perform according to the rules and regulations of the General Medical Council. No one checks how hard locum doctors have worked before starting the locum or how hard they have to work on returning to their normal job.

Thus the NHS has problems with the locum system itself, and not only in relation to foreign locums. In a time of patient safety, clinical governance, quality of care, and so on, should the locum system exist at all?

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Competing interests: None declared.

1 Dyer C. Surgeon's mistakes revive issue of regulation of European locums. *BMJ* 2010;340:c1584. (18 March.)

Cite this as: *BMJ* 2010;340:c1983

UK, wise up

Having moved to Germany to train in surgery, I struggle as a British doctor to find a locum position: there are none open to foreign doctors.[1] It is a long hard struggle even to be recognised as a doctor—the language proficiency test just one of many hurdles before being allowed near a patient.

When will the NHS wise up and follow Europe on patient safety?

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Competing interests: None declared.

1 Dyer C. Surgeon's mistakes revive issue of regulation of European locums. *BMJ* 2010;340:c1584. (18 March.)

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CORONERS

No morbid anatomists remain

The failure of doctors to request necropsies may be because of benign ignorance of the usefulness of the procedure, essentially because of a change of emphasis in medical teaching,[1] but the current legislative bureaucracy is an additional excuse for coroners and medical practitioners to collude in denying the opportunity for a postmortem examination.

In Lincolnshire centralised pathology services are first rate, with more than a dozen consultant histopathologists at the one site in Lincoln. One of those colleagues informs me that you can now train as a histopathologist without being able to do necropsies and that no consultant under the age of 50 does necropsies.

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Competing interests: None declared.

1 Lucas SB. Leadership is needed. *BMJ* 2010;340:c1566. (24 March.)

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JENNER'S STATUE

Leave Jenner in peace

In 2003 Oliver and I proposed in the *Lancet* the removal of Calder Marshal's statue of Edward Jenner from the Italian Garden in Kensington Gardens, where it has rested since 1862, and its restoration to Trafalgar Square.[1 2] The Jenner statue was erected in Trafalgar Square in 1858 on a site in the south west corner of the square adjacent to the statue of Sir Charles Napier and is shown in a contemporary drawing of the square in this position.[3]

I now believe that the statue of Jenner should be left where it is.

Firstly, the statue is not a particularly impressive commemoration of such a benefactor of humanity. Certainly it can't compare with the striking statue in Genoa by Monteverde showing Jenner vaccinating his own son.

Secondly, as Winkelstein suggests in a letter in response to our original piece,[4] the beautiful ponds and fountains of the Italian Garden surely constitute a more appropriate and tranquil location for the great man.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;340:c1980