be linked to job trainability, says the commentary by McManus (p 432), but have less impact on clinical performance, which may require more imaginative and open thinking.

Epistaxis: not to be overlooked in bleeding in cirrhosis

Variceal bleeding is a life threatening complication of cirrhosis, in which survival is closely related to failure to achieve haemostasis. In a clinical review, Johal and colleagues (p 440) describe two patients in whom endoscopic treatment failed to control bleeding. A delay in the diagnosis of epistaxis as the primary cause of the bleeding led to prolonged haemodynamic instability and further decompensation. The authors say that in patients with haematemesis without an identifiable cause at gastroscopy, the mouth and nasopharynx should be examined carefully to exclude a bleeding point.

POEM*

Non-contrast computed tomography is preferable for evaluating asymptomatic microhaematuria

Question What is the preferred imaging study for the evaluation of patients with microhaematuria: computed tomography (CT) or intravenous pyelography (IVP)?

Synopsis Non-contrast computed tomography is more accurate than intravenous pyelography in evaluating patients with flank pain with or without microhaematuria. Less is currently known about the best imaging test for evaluating patients with asymptomatic microhaematuria. In this study, 115 patients presenting to a urology clinic with asymptomatic microhaematuria underwent both CT and IVP before cystoscopy. The two tests were separated by at least five days to avoid contrast-induced renal insufficiency. Scans were evaluated by radiologists blinded to the results of the other imaging study. When clinically feasible, pathological evaluation served as the gold standard. In cases where no histology was available, the study with the higher reported accuracy in the literature for a particular disease entity was defined as accurate. Overall, abnormalities were identified in 38 patients (33%). In 77 patients no cause for haematuria was found on either study. False positive results were reported by CT in two cases and IVP in seven cases. The sensitivity and specificity of the CT scan was 100% and 97.4%; the IVP was less accurate, 60.5% and 90.9%, respectively. Forty non-urological diagnoses were made by CT, including abdominal aortic and iliac artery aneurysms. No additional diagnoses were made by IVP. Although the initial costs of CT were higher, additional radiography was recommended after only four CTs compared with 20 IVPs. Thus, the overall costs were similar.

Bottom line CT scanning is more accurate than the IVP in assessing the cause of asymptomatic microhaematuria. With CT less additional imaging is needed.

Level of evidence Any of *(a)* independent blind or objective comparison; *(b)* study performed in a set of non-consecutive patients, or confined to a narrow spectrum of study individuals (or both) all of whom have undergone both the diagnostic test and the reference standard; *(c)* a diagnostic clinical rule not validated in a test set.

Sears CLG, Ward JF, Sears ST, Puckett MF, Kane CJ, Amling CL. Prospective comparison of computerized tomography and excretory urography in the initial evaluation of asymptomatic microhematuria. *J Urology* 2002;168:2457-60.

* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

Editor's choice
What are journals good at?

This week's ABC of learning and teaching discusses lectures. Lectures are much criticised these days, but Peter Cantillon argues that they are an efficient means of transferring knowledge and concepts to large groups (p 437). He says they may be good for stimulating interest, explaining concepts, providing core knowledge, and directing student learning. What they are not so effective at is teaching skills, changing attitudes, or encouraging higher order thinking.

So how does the *BMJ* square up against those attributes? Though medical journals probably have more in common with lectures than they do with small group learning, there's at least one attempt to change attitudes in this week's *BMJ*. A systematic review by Lucas Bachmann and colleagues on the accuracy of the Ottawa ankle rules (a decision aid for excluding fractures of the ankle and mid-foot) concludes that the rules are an accurate aid, with a sensitivity of almost 100%, and should reduce the use of radiographs by 30-40% (p 417). In his accompanying editorial, John Heyworth points out that the use of the rules remains variable (p 405). Although clinicians in Canada and the UK commonly use them, those in the US, France, and Spain don't. He thinks such resistance is difficult to support given the strength of the evidence. He also commends the development of other, similar rules—for knees, cervical spine, and head injuries—for reducing the need for imaging and transforming the approach to assessing these injuries in a way that can be used by clinicians in both hospitals and the community.

There's plenty of core knowledge in the *BMJ* (see the research articles), and some explaining of concepts (the ABC, the clinical review on chronic dysphagia), but we editors like to think that we stimulate interest. One measure of that is our correspondence columns—and we certainly stimulated reactions from health economists when we suggested that the *BMJ* would consider economic evaluations that accompany clinical papers only if we are sent both to consider (p 445). In response we've clarified our policy (p 446).

As for directing learning, there are several pointers in this week's *BMJ* for readers who want to know more about structural equation modelling. The study on page 429 uses it to find which characteristics best predict performance over the five years of a medical degree. In their comparison of A levels, personal statements, teachers' references, and a personality assessment Eamonn Ferguson and colleagues found the teachers' reference useless. But their structural model showed that conscientiousness was positively related to A level grades and preclinical performance but negatively related to clinical grades. In his commentary (p 432) Chris McManus discusses how structural equation modelling works—with some help from the philosopher David Hume (it's all to do with causality); and Chris Martyn (p 453) finds a website that explains it all rather nicely: *Fun with structural equation modelling*.

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