Letters to the Editor

Diagnostic approach to patients with suspected pulmonary embolism

Sir,

The observation that patients with indeterminate isotope lung scans received anticoagulant therapy without the benefit of validation or refutation of pulmonary thrombo-embolic disease through the use of investigative modalities for lower limb deep vein thrombosis,¹ resonates with my own observation that there is widespread underutilisation of the principle of a 'one stop' facility for streamlining investigation and treatment of common disorders. A 'one stop' facility for investigation of pulmonary thrombo-embolic disease would have ensured that patients with indeterminate isotope lung scans could proceed to an investigative evaluation of the lower limbs for deep vein thrombosis at the same sitting. The generalisability of this principle is exemplified by the investigation of the underlying cause of iron deficiency anaemia in a 'one stop' facility utilising upper gastrointestinal endoscopy and colonoscopy at the same sitting, resulting in one of the highest yields for identification of multiple pathology as the aetiopathogenetic basis of this disorder,² and also reducing the likelihood of delayed recognition of 'clinically silent' underlying causes such as left-sided colonic cancer.³ The authors also addressed the issue of suboptimal concordance between contrast venography and ultrasonography for detection of lower limb deep vein thrombosis, including above knee involvement.⁴ A related issue is that of the strength of the negative predictive value of compression ultrasonogra-

phy of lower limb veins. According to a recent study in which 62 pulmonary arteriograms were performed in suspected pulmonary embolism despite a low-probability isotope lung scan and negative lower limb ultrasonography, the latter does not necessarily rule out the probability of pulmonary embolism, since five of the 62 patients tested positive for pulmonary embolism on pulmonary arteriography.⁴ Ancillary tests such as D-dimer testing,⁵ might prove to be a useful alternative to pulmonary arteriography in the context of the association of low probability scintigraphy and negative lower limb ultrasonography.

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- 1 Saro G, Campo JF, Hernandez MJ, *et al*. Diagnostic approach to patients with suspected pulmonary embolism: a report from the real world. *Postgrad Med J* 1999;75:285-9.
- 2 Hardwick RH, Armstrong CP. Synchronous upper and lower gastrointestinal endoscopy is an effective method of investigating iron-deficiency anaemia. *Br J Surg* 1997;84:1725-8.
- 3 Jolobe OMP. Causes of late diagnosis in cases of colorectal cancer seen in a District General Hospital over a 2-year period (letter). *Ann R Coll Surg Engl* 1998;80:447.
- 4 Meyerovitz MF, Mannting F, Polak JF, Goldhaber SZ. Frequency of pulmonary embolism in patients with low-probability lung scan and negative low extremity venous ultrasound. *Chest* 1999;115:980-2.
- 5 Bounameaux H, de Moerloose P, Perrier A, Reber G. Plasma measurement of D-dimer as diagnostic aid in suspected venous thromboembolism: an overview. *Thromb Haemost* 1994;71:1-6.

An elderly man with dysphasia and pyrexia

Sir,

This was a very instructive case,¹ not least because it cannot be emphasised too strongly that examination of the ears is a 'must' for all patients with neurological disease involving structures above the level of the cervical cord. For the sake of completeness, one should also mention the fourth predisposing category for cerebral abscess, namely, right to left shunt,² including drainage of the right superior vena cava into the left atrium, responsible for cerebral abscess in three of the five cases in the literature review conducted by Smith *et al*,³ who stressed the crucial role of echocardiography and, in selected cases, cardiac catheterisation as well, in the investigation of cerebral abscess when the three aetiopathogenetic mechanisms mentioned by Sathi and Shinton¹ do not appear to be operative.³

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- 1 Sathi N, Shinton RA. An elderly man with dysphasia and pyrexia. *Postgrad Med J* 1999;75:307-8.
- 2 Harrison MJG. The clinical presentation of intracranial abscesses. *Q J Med* 1982;LI:461-8.
- 3 Smith GT, Dorward NL, Coghlan JG, Bradford R. Iatrogenic anomalous drainage of the superior vena cava: an unusual cause of cerebral abscess. *Br J Cardiol* 1999;6:160-2.

Book review

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

Key questions in obstetrics & gynaecology, A Pickersgill, A Meskhi, S Paul, pp xii + 168. βIOS Scientific Publishers Ltd, 1999. £15.95, paperback. ISBN 1 85996 003 0. ★★★★★

This is a wonderful little book and should be essential reading for anybody preparing for Part 2 of the Membership of the Royal College of Obstetricians & Gynaecologists. It is also a useful source of information for practising gynaecologists who find themselves barracked by patients to provide evidence-based statistics for suggested clinical management plans.

The book has six multiple choice papers with 300 questions in each followed by an answer section with justification. Questions

are clinically based and broadly correct. The authors can be forgiven the occasional lapse. The margins of opinion occasionally overlap scientific bias, as in Paper 4, a patient at 12 weeks of pregnancy with micro-invasive carcinoma can be safely carried through to 24 weeks. The logic of picking 24 weeks, though based on viability, is one which many practising obstetricians would question. Surely if one can carry the pregnancy safely from 12 to 24 weeks one could carry it a further 4 weeks to 28 weeks when the shift in neonatal morbidity and mortality is significantly altered.

Occasionally there are lapses in the stems; Paper 2, question 206 suggests that ultrasound, CA125, and genetics are beneficial screening tools. To date, no randomised controlled trial clearly demonstrates that any of

these methodologies are beneficial. Two randomised screening trials are currently underway. Some questions such as the one on the 'confused geneticist' are in themselves confusing and difficult to follow and would benefit from re-writing in a less ambiguous fashion. The use of eponymous terms such as YUZPE, is to be eschewed. The essence of a question should not be obfuscation.

All in all the book is well referenced, easy to read, with sensible evidence-based justifications for the majority of statements. It will be of interest to nascent gynaecologists.

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