prospect of such assessments. Both authors have recently undergone both forms of assessment to allow certification to undertake colonoscopy for the national bowel cancer screening programme. This was quite an experience and probably reflects the stresses/rewards that revalidation will present.

Neither of us had sat an examination of any form for over 10 years, and certainly not had our clinical technique formally assessed by experts. The consequences of failing the certification exam (termed by some as the 'advanced colonoscopy driving test') were obvious. Firstly, our trust would not be able to start the screening programme and the considerable investments already made would come to naught – our recently employed screening nurse specialists would be at best twiddling their thumbs and at worst twiddling their P45s. Secondly, the blow to personal and professional pride/confidence would be huge. The implications of failing the 'driving test' from the point of view of an individual trust or professional society in the long run are as yet unclear.

Prior to the exam we had received a reading list, copies of the DOPS form that would be used, and the details of an exam preparation course. We spent many happy evenings learning polyp classifications, removal techniques, every conceivable configuration a colonoscope could get into and how to get out of them, to our wives' distraction. We examined each other to get used to the process and became obsessed with completion rates, polyp detection and sedation levels. We attended the preparation day which was held at the other end of the M5 and learnt how to use ScopeGuide (whereby the colonic knots formed during the endoscopy are visible for everyone, including the patient, to see), to have our technique constructively critiqued and to undertake a mock DOPS and a multiple choice question (MCQ) exam.

The exam itself was extremely nerve-racking – as bad as the MRCP(UK). One of us sat it at St Marks in London, the other in Torbay. One of our first patients had had a previous 'relatively easy' colonoscopy which on the day turned into an hour-long nightmare; thanks to ScopeGuide, the examiners were able to understand the complexity of the procedure. The patient

also had a vasovagal episode during the procedure requiring a cool fan for both patient and examinee! The MCQ was tougher than the mock version, and then it was over. Over the next couple of weeks we learnt that we had both passed, and four weeks later the screening programme was up and running in Derbyshire.

We both found the process extremely stressful (and expensive!) but feel it has made us both far better colonoscopists. We have re-learned many things we had forgotten, we have been watched by several experts and our technique has improved dramatically (making the procedure shorter and less painful for the patient). Our professional pride has been boosted by the process and we received nothing but positive and constructive feedback from the examiners (who, having been through the process recently themselves, were aware of the stress we were under and did their utmost to reduce it).

Although we did not enjoy the process, it was overall a very positive experience. We know, however, that there are some who have not passed the exam since it started and we empathise with the anguish they must be suffering. Revalidation will not be good news for everyone, but everyone should be better for it.

BOD GODDARD

ROB CUNLIFFE

*Consultant Gastroenterologists
Derby Hospitals NHS Foundation Trust*

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Management of chronic kidney disease: audit-based discussion

Management of chronic kidney disease (CKD) is gaining increasing significance. The guidelines laid out by the Joint Specialty Committee on Renal Medicine of the Royal College of Physicians (RCP), the Renal Association and the Royal College of General Practitioners recommends that all patients with stages 4 and 5 CKD be formally discussed with nephrologists even if renal replacement therapy is not anticipated.¹

We audited management of CKD in Withybush Hospital, a district general hospital, which has no on-site renal services. We compared our practice against the standard set out in the guidelines.

Over a one-year period, 378 patients with abnormal renal functions were identified through our biochemistry department. Of these, 268 patients had either acute renal failure, acute or chronic renal failure, untreated obstructive kidney disease or stage 3 CKD and were eliminated. One was monitored by paediatrics and notes were not available for three patients so all four were also excluded. Of the original number, 106 patients identified to have chronic stable stages 4 and 5 CKD were audited.

Out of 106 patients, 61 (57%) were referred to nephrologists; 19 were diabetic with 14 (74%) referred; and 87 were non-diabetic with 47 (54%) referred. Sixty-two were aged over seventy with 26 (41%) referred and 44 were aged under seventy with 35 (80%) referred.

We found specialist opinion was not

sought in 43% of the patients. Further management plans were not documented and the recommended biochemical tests were not conducted in these patients. Referral rate was higher in younger rather than in older patients (80% v 41%) and in diabetic patients rather than in non-diabetic patients (73% v 54%). The latter was probably due to strict guidelines, increased awareness and frequent review in diabetic clinics.

As our hospital has no on-site renal services, the following recommendations were set out to manage CKD patients.

- our medicine and biochemistry departments will identify patients with stable stage 4 and 5 CKD.
- there are proposals for running a physician-led special clinic from June 2007 in order to facilitate management of these patients in line with the guidelines.

Our practice will be re-audited after the changes are implemented in one year's time.

The prevalence of stage 3 CKD is around

4–5% of which 10% will progress to stage 4 and 5 disease.² Managing all these patients as the guidelines stipulate will cost the trusts much money, time and manpower. Every hospital, especially the ones with no on-site renal service, should foresee the problem and formulate an appropriate referral pattern.

VINOTH SANKAR

Senior House Officer

PRITI GURUNG

Foundation Year 2

K MOHANARUBAN

Consultant Physician

Withybush General Hospital, Haverfordwest

References

- 1 Joint Specialty Committee on Renal Medicine of the Royal College of Physicians and the Renal Association, and the Royal College of General Practitioners. *Chronic kidney disease in adults: UK guidelines for identification, management and referral*. London: RCP, 2006.
- 2 MacGregor MS, Boag DE, Innes A. Chronic kidney disease: evolving strategies for detection and management of impaired renal function. *QJM* 2006;99:365–75.