Characteristics of the study patients (n=53). Values are numbers (percentages) of patients unless otherwise indicated

Characteristics	
Mean age in years (SD)	44.3 (18.5)
Male sex	31 (58.5)
Location of thrombosis:	
Isolated brachial	4 (7.5)
Axillary vein	6 (11.3)
Subclavian vein	14 (26.4)
Axillary and subclavian veins	29 (54.7)
Concomitant symptomatic pulmonary embolism	6 (11.3)
Risk factors for thrombosis	
Thrombophilia*	12 (22.6)
Unusual exercise	11 (20.7)
Active cancer†	11 (20.7)
Recent (<4 weeks) trauma or fracture	6 (11.3)
Previous leg vein thrombosis	6 (11.3)
Recent (<4 weeks) surgery	3 (5.7)
Outlet thoracic syndrome	3 (5.7)
Obesity	3 (5.7)
Heart failure	2 (3.8)
Oestrogens (% women)	5/22 (22.7)
Pregnancy (% women)	1/22 (4.5)
Combination of inherited and acquired risk factors	9 (17.0)
None	8 (15.1)
Initial treatment	
Unfractionated heparin	43 (81.1)
Low molecular weight heparin	10 (18.9)
No of months of follow up	
Median duration (range)	48.3 (1-60)
Median duration of anticoagulant treatment (range)	3 (1-40)‡

*Factor V Leiden in six patients, deficiency of protein C in three, deficiency of antithrombin in two, and prothrombin gene mutation in one.

†Already known or detected during hospitalisation.

‡Longer than six months in four patients.

Residual thrombosis was related to the incidence of post-thrombotic syndrome (hazard ratio 4.0, 1.1 to 15.0). Of other potential risk factors, only thrombosis affecting the axillary and subclavian veins was related, albeit not significantly, to the development of

post-thrombotic syndrome (hazard ratio 2.9, 0.8 to 10.7).

Comment

Symptomatic deep vein thrombosis of the arm carries a low risk of recurrent thromboembolism. Post-thrombotic sequelae occur in almost one fourth of patients within the first two years and are related to residual thrombosis and, to a lesser degree, to the extent of the initial thrombosis. The rates of recurrent thromboembolism and post-thrombotic syndrome are lower than those observed in cohorts of patients with venous thrombosis of the leg.⁴ Whether the incidence of long term sequelae might be further reduced by physical devices or other methods is worth investigating.

Contributors: PP, AWAL, AG, and EB conceived and designed the study. PP, AWLA, MHP, and EB drafted the article. MHP and AM offered their statistical expertise for analysing and interpreting data. PP, SV, PB, DS, AP, and PS provided study patients and collected data by following them prospectively over years. AG, AP, AM, and PS critically reviewed the article for important intellectual content. All authors approved the final version of the article. PP is guarantor.

Funding: None.

Competing interests: None declared.

Ethical approval: Institutional Review Board of Padua University.

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(Accepted 24 May 2004)

doi 10.1136/bmj.38167.684444.3A

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Sir Gordon Gordon-Taylor and me

In the late 1950s I became a surgical registrar at a well known hospital in South Wales, though I was still unsure where my future might lie. Shortly after my arrival, there was general excitement that the (reputedly) greatest living British surgeon, Sir Gordon Gordon-Taylor, had accepted an invitation to come from London to see an unfortunate patient who had a malignant tumour affecting his pelvis. Subject to the patient's agreement and Sir Gordon's opinion, it was felt that a hindquarter amputation might be the only possible treatment.

Sir Gordon was kindly and charming, dressed as the archetypal surgeon with a double breasted suit, bow tie, and a pink carnation in his buttonhole. Despite his fame, he had not lost the common touch and spoke with genuine interest to everyone he met, particularly the most junior doctors and nurses. I have since calculated, to my great surprise, that he was at least 80 at the time.

The amputation went well. Sir Gordon was assisted by three consultants, and, as the fourth assistant, I had little to do apart from carrying away a very large specimen. Sir Gordon was at pains to ensure that all could observe how the procedure went. For the most part, he used only a scalpel with bold and graceful strokes, and stood back while his highly skilled assistants controlled the bleeding and ligated the main vessels.

As is the custom with visiting luminaries, he was asked to give advice about other problematic patients. One, who had just been admitted, was a middle aged man with a six month history of a massive, fixed, and painless swelling of his right shoulder, which was thought probably to be a soft tissue sarcoma. My consultant and I escorted Sir Gordon to see this patient, for whom he agreed that a forequarter amputation might be considered, but noted that a biopsy had not yet been done, and I was instructed to do this.

The biopsy, performed the next day under general anaesthesia, resulted in the release of a huge volume of pus and the cure of the patient. Delightedly, he went home a day or so later, performing windmill movements with his hitherto useless right arm. I never saw anything similar in the rest of my clinical career.

Sir Gordon was the first really famous medical person that I had met. I cannot say that the experience convinced me that I should pursue a career in surgery, but he did make other careers seem less interesting. Unfortunately, he died a year or so later after an accident.

David Crosby *retired surgeon, University Hospital of Wales*