The ups and downs of vascular surgery

Sir,

We read with interest the article by Bicknell and Hussain (vol 67(6), 2006, pM119). It does well to recognize that vascular surgery is a field in which the diagnostic process itself is paramount, and the surgery is highly rewarding although technically unforgiving.

We feel the article is frustratingly vague with regard to vascular training. The authors elude to a shifting emphasis towards angioplasty, stenting and endovascular repair. Unfortunately, beyond that, they skirt around the grey area of the Modernising Medical Careers (MMC) programme but offer little objective information or advice about either the existing or proposed training pathway and its content. This is sure to leave the prospective applicant confused, uncertain about prospects and with lack of direction.

Having worked on a busy vascular firm, we are all too aware of the demanding nature of the work. Nevertheless, the outlook could have been made more appealing. A rather bleak picture is painted by phrases including 'you may regret the decision often', 'family life may suffer' and 'downright depressing'. It was a shame to find ambassadors of vascular surgery expressing such a cold and ruthless outlook. We would be surprised if even a handful of readers were left with any sense of optimism or attraction towards what is truly an exciting and promising specialty.

Arun Prabhu
Senior House Officer in General Surgery
Sarah Edwards
Foundation Programme 1 Doctor in Vascular Surgery
Ben Sassi
Registrar in Vascular Surgery
Mike Lewis
Consultant Surgeon in Vascular Surgery
Royal Glamorgan Hospital
Llantrisant CF72 8XR

Sir,

The comments made by these authors regarding vascular training are totally justified. The problem is that the framework for the new MMC programme is frustratingly vague and not our interpretation of it. The programme is being developed at the present time and the Vascular Society is in negotiations with the Royal College of Radiology to try and involve endovascular training. The future is uncertain in this regard.

As ambassadors of vascular surgery we tried to give a balanced and honest view of a demanding specialty which requires the right person to take up the challenge. Those with 'rose-tinted spectacles' are not right.

Every specialty has advantages and disadvantages and we have attempted to show both so that future entrants into our specialty will know what to expect. We believe that there are large cohorts of enthusiastic, hard-working young doctors that will rise to this challenge and dispute the comments that only a handful of readers will be attracted to this specialty.

Colin Bicknell/Tahir Hussain
Specialist Registrar/Consultant Surgeon
Northwick Park Hospital
Harrow HA1 3UJ

Intubation alternatives in accident and emergency

Sir,

As anaesthetists, the authors would like to emphasize the importance of airway management, especially in critically ill patients. These patients frequently present out of hours in the accident and emergency (A&E) department. They can be very unforgiving if their airway is not secured immediately. They may be comatose and are at a high risk of aspiration. The authors recently experienced an elderly gentleman who presented in respiratory failure and with a low Glasgow Coma Scale. He was unable to protect his airway and had just been fed through his percutaneous gastrostomy. Although the authors could oxygenate, they were unable to intubate him. This case highlighted the importance of protecting the airway from ongoing aspiration.

The patient was discussed in a departmental teaching session. Following this the authors believe that it is necessary for the Association of Anaesthetists of Great Britain and Ireland (AAGBI) (2000) minimum standards of monitoring to be applied to A&E as well. This is because the task of securing the airway in critical patients arises most frequently in A&E.

The authors conducted a telephone survey of hospitals in Kent and enquired after the availability of difficult intubation equipment and the facility of end tidal carbon dioxide ($ETCO_2$) monitoring in the A&E department. The findings showed that the only alternative airway available was the laryngeal mask airway and some district general hospitals did not have $ETCO_2$ monitoring. The authors conclude that specific guidance regarding availability of difficult airway equipment and $ETCO_2$ monitoring in A&E issued by the Difficult Airway Society (Henderson et al, 2004), AAGBI or the Royal College of Anaesthetists would be very useful.

Pooja Warty
Senior House Officer
Richard Thomas
Senior House Officer
Mansoor Sange
Specialist Registrar
Department of Anaesthetics
Medway Maritime Hospital
Gillingham
Kent ME7 5NY

Association of Anaesthetists of Great Britain and Ireland (AAGBI) (2000) *Recommendations for Standards of Monitoring During Anaesthesia and Recovery*. Association of Anaesthetists of Great Britain and Ireland, London

Henderson JJ, Popat MT, Latto IP, Pearce AC (2004) Difficult Airway Society guidelines for management of the unanticipated difficult intubation. *Anaesthesia* **59**(7): 675–94

Correction

In the article *Supplements and injections for joint disease* (vol 67(6), 2006, p. 290), it was stated that a number of hyaluronate agents required several injections on a weekly basis and were approved only for knee injections. The authors would like to clarify that Durolane is a single joint injection and is approved and indicated for both hip and knee osteoarthritis. We apologise for the error and any confusion caused.