Simple education to drive thromboprophylaxis provision

Sir,

We read with great interest your symposium on venous thromboembolism, as it echoes our own feelings on its prevention, or rather the persistent lack thereof. Since writing an editorial on the subject a year ago (Findlay et al, 2008) the evidence base has become yet more conclusive, as has the availability of simple guidelines (National Institute for Health and Clinical Excellence, 2007; Geerts et al, 2008). However, their recommendations continue to be neglected (Hunt, 2009).

Professor Kakkar (vol 70(7), 2009, p. 386) correctly suggests that the advent of new oral anticoagulants may improve clinical outcomes, yet we would maintain that the root of the problem is more fundamental. Simple educational initiatives can improve care, such as the mnemonic 'MONA' for myocardial infarction. A generation of medical students and junior doctors now knows automatically how to initially assess and manage this problem, so why is this not the case for venous thromboembolism?

We believe that education and awareness remain the limiting factors in thromboprophylaxis provision rather than the ultimate form of prophylaxis itself. While admitting patients doctors automatically prescribe analgesia and their regular medications, yet give little thought to thromboprophylaxis. Indeed, venous thromboembolism is very much an afterthought, often seen as 'just one of those things'. We would argue that the profession should remain outraged that a condition suffered by 20% of our patients and contributing to 10% of hospital deaths is still seen this way (Sandler and Martin, 1989; Mismetti et al, 2000; Geerts et al, 2008) and that an analogous campaign is long overdue.

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Anatomy dissection: a valuable surgical training tool

Sir,

The opportunity to dissect a cadaver has usually been the preserve of the medical student or anatomy demonstrator, but it is rarely used as a training tool for those actively participating in surgical training. Over the last year, as part of a module contributing to an MSc in Surgical Sciences, I have had the opportunity to extensively dissect an area of anatomical interest, my first experience of dissecting since being a medical student and one which highlights the potential use of this activity as a valuable surgical training tool.

Having agreed a suitable dissection project with a designated supervisor, a cadaver is assigned and from that moment on, the responsibility lies with the student to maintain and care for the cadaver during the dissection period. Indeed, a poorly maintained cadaver can count against the student when the overall dissection is finally assessed. Much of the dissection is deliberately unaided with only a limited amount of supervision provided. There is therefore considerable emphasis on the student to plan accordingly and find the best approach to achieve a successful dissection. Anatomical atlases and dissection guides are provided, but often the student is required to improvise to overcome certain obstacles and perhaps adopt new and unfamiliar approaches to adequately expose the area of interest. As a result, there is a greater level of involvement and interaction with the dissection than most students experience during the pre-clinical years of medical training when dissection can often represent a token part of the core anatomy teaching. At the end of the dissection, the student is assessed by means of a written essay and viva examination.

On a personal level, I was able to choose a project relevant to my area of surgical interest. Having recently completed basic surgical training, this was an excellent opportunity to cement and improve my anatomical knowledge before undertaking higher surgical training and it also brought other skills that were transferrable to the clinical setting such as the opportunity to improve my dexterity and problem solving. The major advantage of such an experience is the considerable time afforded to dissect, a luxury unavailable to most medical students and trainee surgeons. This, together with the emphasis on independent dissection, facilitated a much greater level of interaction, awareness and appreciation of anatomical structures, particularly in a three-dimensional context, than could possibly be achieved by reading alone or using models. As a result, this has greatly improved my confidence in applying anatomy to the clinical setting, both by the bedside and in theatre.

Anatomy dissection could have a useful role to play in the training of surgeons, particularly for junior trainees and perhaps even as an alternative to anatomy demonstrating. Currently, anatomy dissection does not form part of the surgical curriculum and there would be concerns regarding the limited number of cadavers potentially available for such an activity, but if offered on a limited basis to those who were interested and were able to provide a regular commitment, anatomy dissection would certainly be a beneficial and unique exercise for those wanting to improve their knowledge and confidence in anatomy.

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