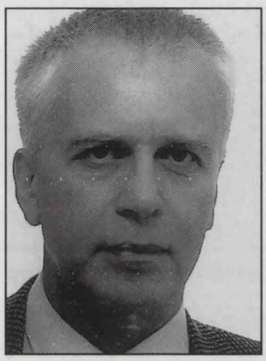
NEWS & NOTES

New Appointments

Consultant radiologist



John McGregor has been appointed as a consultant radiologist, a position he will take up in February 2001.

Born and educated in Belfast, John graduated from Manchester in 1977 and his postgraduate posts up to medical registrar were in the northwest. In 1982 he began the Manchester training scheme in diagnostic radiology.

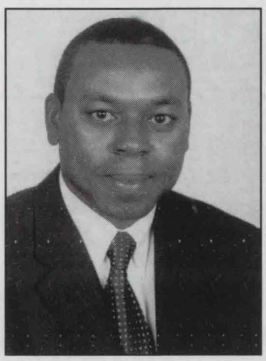
A consultant since 1987 in Lancashire and Northern Ireland, John has a number of special interests within radiology. In Manchester he trained in gastroenterology, including endoscopic biliary procedures, an interest he has strongly maintained. Enthusiasm for cardiology from his medical days led to non-invasive cardiac imaging using radionuclides and ultrasound and in the last few years this has extended to paediatric, neonatal and fetal echocardiography. This cardiovascular interest also extended to the setting up of a non-invasive vascular service for peripheral arterial and venous disease using ultrasound and spiral CT angiography.

In the last few years, John has developed a keen interest in musculoskeletal disorders and sports injuries and the use of high-resolution ultrasound for diagnosis and the guidance of appropriate therapy. He is particularly looking forward to extending this interest with the new MRI in Lancaster.

John's longterm fascination with how the world works resulted in the recent completion of a BSc with the Open University in Natural Sciences and he is looking forward to exploring the geology and ecology of the Lake District and surrounding areas. Other outdoor interests include canoeing and sailing. John is a qualified yoga instructor and is currently studying for a diploma in yoga therapy.

He is married with two children.

Consultant Ophthalmologist



Gilbert Ozuzu was born in Nigeria and graduated from the University of Nigeria in 1986.

He came to the UK in 1991 to continue his postgraduate medical training.

In 1992 he successfully completed an MSc in ophthalmology by advanced study and research (Bristol University), and he gained the Diploma in Community Eye Health from the Institute of Ophthalmology and University College London in 1994.

He undertook basic specialist training (SHO) at Bristol Eye Hospital and in Coventry, and higher specialist training in the Northern and West Midlands deaneries, working at the Royal Victoria Infirmary, Newcastle, Sunderland Eye Infirmary, North Riding Infirmary, Middlesborough and Wolverhampton Eye Infirmary.

Gilbert developed a special interest in glaucoma and cataract surgery and undertook advanced subspeciality training in cataract surgery at Arrowe Park Hospital, with an interest in multifocal intraoscular lens implants. He also undertook a Glaucoma Fellowship at Moorfield Eye Hospital in London and a short fellowship with the glaucoma service at Duke University Eye Center in Durham, USA.

Gilbert hopes to develop a modern glaucoma service within Morecambe Bay.

He enjoys football, lawn tennis, fitness training, swimming and chess.

Cricket Report

Lancaster district GPs v consultants match Venue: Arnside Cricket Club Date: 7 June 2001

After letting a seemingly assured victory slip away in last year's fixture the Lancaster GPs were in determined mood on a bright but chilly June evening. Winning the toss they inserted the consultants who generally struggled against some accurate and occasionally hostile GP bowling. The backbone of their 110 runs, scored in 20 overs for the loss of 6 wickets, were scores of 30 by Colin Brown, and a cultured 32 from Chris Till. Both retired gracefully!

Without an early breakthrough the consultants' score was felt unlikely to be sufficient without early wickets. Unfortunately these were not forthcoming and John Yarnall and Jeremy Marriott were both in imperious form as they swept to 34 and 32 respectively. On their retirement it was left to John North, 22 not out, to steer the GPs past the required total with an over and a half remaining.

A delightful evening, the friendly competition was brought to a close with an excellent tea provided on behalf of the consultants. The Brian Higton trophy was thus secured by the GPs in its second year. They have no intention of relinquishing it for some considerable time!

Letters to the editor

Thromboembolic disease

Sir:-

I write to you with regard to the excellent series of articles in the September 2001 issue of the Morecambe Bay Medical Journal concerning thromboembolic disease. I have, however, some comments which arise specifically from a vascular surgical perspective to this common condition. Dr Wales rightly points out the potential complications of thromboembolic disease but I do not think she gives enough emphasis to the post-thrombotic syndrome. Clearly, any treatment for thromboembolic disease at the time of the acute event can be seen to reduce the risk of pulmonary embolism and further peripheral thrombotic disease. However, the problem with post-thrombotic syndrome is more longterm, and is one which we face on a regular basis in the vascular clinic with damage to the veins and in particular their associated valves. This leads to the post-thrombotic syndrome and the systems described in the article. Ulceration in the presence of post-thrombotic syndrome is a particularly difficult condition to treat, given the nature of the underlying venous disorder. Practitioners should therefore be aware that prompt and adequate treatment of the thrombosis within the limb is vital to reduce the incidence of post-thrombotic syndrome.

I also have a comment with regard to the use of venography for calf vein thrombosis. Dr Wales suggests that if a calf vein thrombosis is suspected, a venogram may be more appropriate. My understanding of the literature is that calf vein thromboses in themselves do not require treatment and therefore I think that venograms should only be done on very rare occasions. Certainly if the duplex scan does not show a clot within the popliteal, superficial femoral, common femoral or iliac veins then I think this is adequate imaging of the legs and there is no need to proceed to a venogram.

With regard to the imaging for pulmonary emboli I think it is worth reinforcing that the gold standard for this type of imaging is currently pulmonary angiography, although this may be replaced in the future by spiral CT angiography and/or MRI imaging.

One of the advantages of performing a pulmonary angiogram, however, is that the catheter can be left at the site of the embolism and high-dose bolus thrombolytic agent can be passed directly to the clot. Although there is no specific evidence to favour systemic thrombolytic therapy versus local thrombolytic therapy, it would seem sensible to get the highest dose of thrombolytic agent to the clot itself. With regard to the actual thrombolytic agent used, I think there is an advantage to using tissue plasminogen activator as opposed to Streptokinase, given the problems with Streptokinase.

On the theme of thrombolysis, I would also like to draw the attention of practitioners to the role of venous thrombolysis for proximal DVTs. Dr Wales has nicely listed the complications that can result from proximal DVTs and there is now increasing evidence that a catheter-directed thrombolysis of proximal vein DVTs can reduce the incidence of pulmonary emboli, post-thrombotic syndrome and recurrent DVTs. The other interesting fact about thrombolytic treatment is that in a larger series of venous thrombolysis an underlying anatomical abnormality has frequently been discovered and there is the opportunity now to treat these endovascularly. In particular with regard to lower limb DVTs there is some evidence that these may be more common in the left leg that in the right leg, which may be attributable to the left common iliac vein being crossed and compressed by the right common iliac artery. Certainly in one of the larger series of venous thrombolysis in this country this was a common finding. One of the main advantages of using thrombolytic treatment for DVTs is the preservation of vein wall and valve function. It is on the basis of this that the problems with post-thrombolytic syndrome may be reduced.

The final point with regard to thrombolysis is to draw practitioners' attention to the role of intra-arterial thrombolysis in the presence of phlegmasia cerulea dolens, where it appears that extensive venous thrombosis has propagated into the arterial system and these cases seem to benefit from intra-arterial thrombolysis.

Stuart Walker
Consultant General Surgeon
Royal Lancaster Infirmary

Sir:-

I will deal with the issues that Mr Walker raises in turn. Firstly, I do agree that post-thrombotic syndrome is an extremely important complication of DVT. This can be prevented by timely and accurate diagnosis and the institution of anticoagulant therapy. All our patients are provided with compression stockings, which they should be encouraged to wear for a minimum of two years. This has been shown to reduce the incidence of post-thrombotic syndrome[1].

Deep vein thrombosis (DVT) and acute pulmonary embolism (PE) are two manifestations of the same disorder: venous thromboembolism. This concept is supported by the fact that over 90% of cases of acute PE are due to emboli emanating from the proximal veins of the lower extremities. The risk of thrombolembolism from calf veins is felt to be sufficiently low that anticoagulation can be safely withheld. However, a small proportion of isolated calf vein thromboses will propagate and pose a risk of PE. If a patient has a positive clinical score for DVT and/or a raised D-dimer, but the ultrasound is negative, then ideally this should be repeated in two weeks to ensure that there has been no clot propagation. A venogram would be an appropriate test if there is a discrepancy between the clinical findings and the results of non-invasive studies or when a Doppler is not feasible.

Pulmonary angiography has long been considered the gold standard for diagnosis of pulmonary emboli. Despite this, it is readily available in only a very few centres. A CT pulmonary angiogram is likely to become the test of choice as it is becoming widely available and we hope will be available in Lancaster shortly. This may ultimately replace V/Q scanning but would certainly be the test of first choice in patients with abnormal CXRs.

Lastly, the use of thrombolytic therapy in the treatment of DVT is controversial, since most patients pursue an uncomplicated course when treated with heparin and warfarin. Randomised controlled trials of Streptokinase and rTPA suggest that the rate of lysis and likelihood of normal follow-up venography are greater with these agents than with heparin[2,3]. This may be associated with a reduction in the risk of post-thrombotic syndrome, but this has not been definitively proved. Provided there are no contraindications

thombolysis could be considered in patients with occlusive proximal DVT associated with significant swelling and symptoms, such as phlegmasia cerulea dolens. Thrombolysis may be more appropriate for younger patients as post-thrombotic syndrome could develop over a very extended period.

D Wales
Consultant Physician
Royal Lancaster Infirmary

References

1 Dees PM Brandjes, Buller HR Heijboer et al. Randomised trial of the effect of compression stockings in patients with symptomatic proximal vein thrombosis. Lancet 1997; 349:759-62
2 Rogers LQ, Lutcher CL. Streptokinase therapy for deep vein thrombosis: a comprehensive review of the literature. Am J Med 1990;88:389
3 Goldhaber SZ, Meyerovitz MF, Green D et al. Randomised controlled trial of tissue-plasminogen activator in proximal DVT. Am J Med 1990;88:235

Retired GPs Lunches

These informal meetings, held twice yearly at The Shrimp Inn, Lancaster Road, Morecambe, are open to local retired GPs and to retired GPs who have moved into the area. The established format is for there to be a meeting in March, on the third Thursday, and a meeting in November, on the first Thursday, at 12.30pm.

Dates for 2002 are March 21st and November 7th.

British Dental Association

LANCASTER AND MORECAMBE SECTION
FURNESS AND SOUTH CUMBRIA SECTION

Secretary: Dr VJ Hadden
01524 702319
dyervj@supanet.com

MEETINGS FOR 2002

Tuesday January 15th 2002
7pm sandwiches. 7.30pm meeting
Lancaster Postgraduate Medical Centre
Olly Keith
Compromises and disguises

Tuesday February 19th 2002
7pm sandwiches. 7.30pm meeting
Education Centre, Westmorland General Hospital, Kendal
Francis Hughes, Professor of Peridontology
Barts, London
Advances in assessment of periodontal disease – choosing the right treatment for the right patient

Saturday March 2nd 2002
Lancaster House Hotel
Presidential dinner and dance

Tuesday March 12th 2002
7pm sandwiches. 7.30pm meeting
Lancaster Postgraduate Medical Centre
Local GDPs clinical presentations

Tuesday April 19th 2002
7pm sandwiches. 7.30pm meeting
Lancaster Postgraduate Medical Centre
AGM

LANCASTER MEDICAL BOOK CLUB

It was in November 1823 that the Lancaster Medical Book Club was established for *Medical Gentlemen resident in Lancaster.* At a cost of one guinea a year the members were entitled to order books, and these were circulated between the members. Within four years the social aspect of the club was developing and members often met to celebrate marriages and the birth of children (marked by a fine of two bottles). In 1877 the first professional paper was read by William Hall, a visiting surgeon at the infirmary and this marked the establishment of the book club as a flourishing academic medical society.

The ethos of the book club remains the same today and membership is open to all medical practitioners in the area. Each year the president arranges a programme of social and academic events which, although costing more than one guinea, are well worth attending. In addition there is an annual golf tournament and a dingy sailing race, or for those with an interest in medical research, it is worth entering for the book club prize. Details of all these events can be obtained from the secretary at Lancaster Postgraduate Medical Centre.

LONGOVICUM TROPHY

This annual dingy sailing race will take place on Coniston Water on Sunday, 26th May 2002. If you are interested in participating please contact Dr A Paton on 01524 39633.

GEORGE CUP

The annual golfing tournament will on Sunday 12th May 2002. Details will be available nearer the date.

Forthcoming programme

25 January 2002
Burns Night meal
Lancaster Golf Club

22 February 2002
'Medical officer with the scientific team in Georgia and the Antarctic". Darranee Boon

Further meetings will include a medico-legal debate

For further details please contact the LMBC secretary, Monica Placzek, c/o Postgraduate Medical Centre, RLI, tel 583951