The Need for Revising the MRCP Regulations

Sir,

The current MRCP regulations are particularly detrimental to overseas doctors who want to have this qualification.

With several centres now opened by the Colleges in Asia and Africa for Part I of the MRCP, the examination has been truly and genuinely internationalized. However, during the framing of the Part II regulations no deep consideration has been given to the employment situation and training capacity of these countries as well as other countries of the Third World from whence come the candidates for this purely British style examination.

First, a 5-year limit has been set to clear Part II — from the date of passing Part I. This ensures that overseas doctors, at that stage, must ignore the rural health service of their respective countries (including both voluntary and mandatory) and must gravitate to large hospitals at the first opportunity. Even this may not solve the problem of training as the specific MRCP courses are either non-existent or only one or two in number.

These are in abundance in the UK and provide examples of a range of cases and styles required for the clinical section of Part II. Therefore, not surprisingly, such candidates try to obtain scholarships for the UK. The standard duration of such scholarships is 3 years and the candidate tries his/her best to pass, but in the process has no choice but to appear again and again. This means that if he or she completes the maximum allowable six attempts, then the Third World scholarship is wasted. Ultimately, more than 25% never pass Part II because of this limit on attempts.

Those overseas candidates who cannot get a scholarship go as private students, and have the option of either passing PLAB (which takes 1 year and has a maximum pass-rate of 28%) and get a job in geriatrics or remain in the UK to do MRCP courses and take examinations again and again.

One might ask ‘why so often’? The reason is that the UK Home Office does not allow extension of stay unless shown the entrance examination letter each time. Even with such a plea the maximum time allowed for private study candidates is often 2 years, so the pressure to sit examinations often has been present for years. This explains why so many overseas doctors have finished their six attempts in the last few years and are back home doing private practice in ENT and ophthalmology after spending 6 or 7 years getting their training in medicine. So much for the services which the Royal Colleges of Physicians (UK) are rendering for the causes of internal medicine beyond the frontiers of the UK.

As the Colleges cannot ensure equal training opportunities to the 3000 MRCP candidates who appear every year, and as the Colleges do not run any long MRCP training programmes, and because the Royal Colleges of surgery and gynaecology and Obstetrics maintain high standards without such restrictive regulations, then the bar on time and number of attempts should be lifted. The Australian Royal College allows two chances in clinicals to those who pass the written section, in each attempt.

The second point in favour of lifting these restrictions is that the examination itself is inadequate in terms of time, range and fixed reproducible standard. For example, it is extremely common to pass the written section once and fail it the next time and pass it again just to fail it the next time. This game goes on and on and even if a candidate obtains the usually maximum score of 17 points out of 20, he or she has to take the written section again. In an average attempt about 37% of candidates stop at the written part as they are not allowed to proceed to the clinical. One is not allowed to defend the answers and opinions in the written part. Disputes about the marking of the paper are settled by college employees and the standard practice of referring to two independent examiners is not followed. Also, unlike the ECFMG authorities in the USA who allow hand re-checking of computer marked answers at extra charge — no such facility exists for the candidates taking MRCP Part I.

Furthermore, a whole system is frequently represented by a 4-minute short case in the Part II examination — such is the depth and time given to test the candidates.

These restrictions on Parts I and II will one day make these examinations, together with internal medicine as a whole, an unattractive and risky option for candidates. At present, the pass rate of foreign doctors at Part II is a little over 20% compared with the pass rate of UK qualified doctors of a little below 40%.

The regulations of the Royal Colleges of Physicians, the Home Office, and the General Medical Council do not help to provide equal opportunities. There is perhaps a need for a new Royal College co-ordinating with the Department of Health and the universities and institutes of specialized training to impart real training to candidates. Such a proposed institution might be more sympathetic to the cause of Third World doctors and respond to the challenges of ‘glasnost’ and ‘perestroika’ which are not only for Soviets.

Another option is the possibility of co-ordination between existing Asian and African postgraduate bodies into a single unified system. The Arab Board, The West African Board, UNICEF, OIC and OAU could help in the setting up of such a system to provide equal opportunities for all.

E.M.S.

Name and address supplied

Sir,

Your correspondent criticizes the MRCP examination on the following grounds:
1. It is UK oriented.
2. Marks in Part I (multiple choice, marked by computer) are not re-checked on request.
3. Part II must be completed within 5 years of passing Part I.
4. The number of attempts allowed at Part II is only six.
5. Disputes about the Part II written section are settled by ‘college employees’.
6. Insufficient time is given to short cases in the clinical

I have done my best to answer your correspondent’s complaints but I can easily see why he makes some of them. It is hard to have to come to the UK to take clinicals and then to be examined in what may be unfamiliar surroundings. It is certainly wise to work and study in this country before taking the examination and that involves time and money. I do not believe it would be a kindness on our part to offer more of the first — I wish we could offer more of the second.

H.
Acute experimental conditions, for example, the therapeutic dose of sucrose is 50 mg/kg whereas doses of 300–1000 mg/kg were used to evaluate its effects on the experimental gastric lesions in rats. At present the antiulcerogenic factor present in honey is not known. However, carbohydrates (constituting 80% of its composition) were without any protective effects. Thus, the question of volume would not arise, if it was possible to isolate the protective factor present in honey. Furthermore, substantially lower doses have been found to be effective depending on the time of administration of the honey (unpublished observation).

We agree that bees can produce honey which is poisonous. By far the largest number of such harmful honeys are reported to be produced from species of rhododendron, azalea, androsmidae and kalmia. The honey used in this study did not fall in those categories. Furthermore, honey can cause hypersensitivity reactions in susceptible individuals.

2. We considered with their suggestions for chronic pain treatment. However, as far as we know, there is no suitable animal model resembling human gastrointestinal ulcers. Studies are in progress to answer this question in the near future.

3. No attempt has been made to elucidate the mechanism of action of honey in this study. However, it is well established that cytoprotective prostaglandins afford protection against both indomethacin and ethanol-induced gastric damage. Similarly, the H2-blocker, cimetidine (100 mg/kg, i.e., 2000 mg for 70 kg humans), inhibited indomethacin-induced gastric lesions but failed to protect against ethanol-induced damage at a dose of 200 mg/kg in rats. Thus, it was thought that inclusion of these reference substances would not provide further new information unless parameters such as acid secretion, mucus determination etc., were studied and the results compared with those obtained using honey.

4. We have no comment on this question. Finally, we would like to say that our paper was a preliminary report on the effects of honey on gastric damage. It was not possible to investigate and to incorporate every detail in a single paper.

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References


Letters to the Editor

thought of to be made. Diagnosis has only to be
influenced by the disease. Although the disease probably does
not test significantly to the severe degenerative changes in the
spine and large joints. Few cases of a ruptured tendo-
achilles secondary to ochronosis have been reported.
O'Brien et al. report only two cases. The ruptures in
this case were at the insertion of the tendon into the os
calcaneum, compared to rupture at a higher level
commonly seen.

Here we report alkaptonuria/ochronosis in a Saudi
male which, to our knowledge, is the first case reported in a
Saudi. A detailed case report is under preparation
and will be published later.

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References
2. Modilevsky T, Manor E, Marmor A. Monogr Hum Genet
3. O'Brien WM, La Du BN, Bunim JI. Biological, pathologic
and clinical aspects of alkaptonuria, ochronosis, ochronotic,

SIR,

I am most interested to read the letter from Drs
Kagalwalla and Beg reporting a case of spontaneous
rupture of tendo-achilles on both sides due to degenerative
changes caused by the deposition of polymerized
homogentisic acid. The diagnosis of ochronosis is
variably missed in the early stages, therefore, it should
be kept in mind in dealing with an unusual musculo-
skeletal disorder. It must be remembered that a case of
alkaptonuria could also present in an Eye, ENT,
Dermatology, or Cardiology Clinic. The simple test of
voiding the urine in a glass jar and leaving it to stand
overnight helps in making the diagnosis. In a case of
alkaptonuria the urine, if allowed to stand, becomes dark
brown. This can subsequently be tested in the laboratory
for homogentisic acid.

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Gastrointestinal Complications
of Behçet's Disease

SIR,

A 41-year-old Yemeni truck driver was admitted to Asir
Central Hospital (ACH) with fever and 30 kg weight loss
over 2 months. His past medical history was negative and
systemic enquiry was not contributory.

On examination, he was sick-looking with a temperature
of 38°C. He was pale but had no lymphadenopathy. The
rest of the examination was normal except for a 0.5 cm
tender ulcer on the left scrotum and a smaller one over
the adjacent thigh.

On further questioning at this point, he reported that
he had scrotal ulcers for 2 weeks and mouth ulcers 6
months before.

The complete blood count was normal except for
a haemoglobin of 10.6 g% and an ESR of 122 mm/h.
Several blood smears and cultures were negative.
Blood chemistry including liver function tests were
normal. Urinalysis was normal. Stools for ova, para-
sites and occult blood were negative. The chest
radiograph, ultrasound of abdomen and the echo-
cardiogram were normal. Tests for VDRL and HIV
were negative. Serologies for brucella, typhoid and
toxoplasma were negative. Anti-ANA and anti-
DNA were negative. A Mantoux test was positive
and so was the serology for kala-azar.

Three weeks after admission, he developed pain-
less melena requiring blood transfusions. No
source of bleeding could be detected by either upper
gastrointestinal endoscopy or sigmoidoscopy.

He developed acute abdomen 4 weeks later
and emergency laparotomy revealed peritonitis and
multiple perforations along the 20 cm length of
the terminal ileum which was resected. Histopathology
revealed transverse ulcers and non-specific enteritis.
Antibiotics and later antituberculosis medications
were administered but patient continued to be
febrile. As the diagnosis of Behçet’s disease was
entertained even from the start, prednisone was
administered.

While on steroids, he developed a fistula at the
previous site of a drainage tube in the right iliac fossa
which later bled massively. An urgent ultrasound and CT
scan of the abdomen revealed a large abdominal aortic
aneurysm.

He was referred to King Khalid University Hospital
in Riyadh where he had aneurysmectomy. He did extremely
well on steroids until 1 year later when he again presented
with abdominal pain and an ultrasound revealed another
huge abdominal aortic aneurysm for which surgery was
recommended.

Even though Behçet first described the disease with
only dermatological manifestations, subsequent reports
in the literature have proven that Behçet’s disease is a
multisystem disease with protein manifestations.1–3
During his prolonged hospitalization, the patient
described above developed a constellation of dramatic
signs and symptoms, particularly related to the
gastrointestinal tract. He developed massive GI
bleeding with undetermined focus requiring blood
transfusions. He later developed an acute abdomen
with perforations of the terminal ileum and peritonitis.
Non-specific ulcerations of the small intestine occur in
Behçet’s disease, 75% in the ileum and caecum, and
the rest in the jejunum, colon and oesophagus. They may
present with signs of bleeding, abdominal pain or mass,
obstruction and/or perforation1–3 as they did in our
patient.
This case illustrates the serious GI manifestations with which patients with Behçet's disease may present.

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References

Can Echocardiography Predict Selenium Deficiency in Patients on Home Parenteral Nutrition?

Sir,

The association between selenium deficiency and congestive cardiomyopathy in humans, has been well documented.1,2 Patients on home parenteral nutrition (HPN) are a group particularly at risk.3,4 Unfortunately, measurements of plasma selenium and red cell glutathione peroxidase (RCGP) levels are not widely available tests. We used echocardiography in patients on HPN to assess their left ventricular function and to determine whether this technique can identify patients with selenium deficiency prior to the onset of clinical symptoms. Thirty-two British patients (16 males, 16 females) on HPN for 6 months to 8 years were studied at Hope Hospital. The ages ranged from 18 to 37 years (mean 25 years). Echocardiographic measurements and assessments were carried out without prior knowledge of the selenium and RCGP results. The Mann–Whitney U-test and Spearman correlation coefficients were used for statistical analysis.

Selenium deficiency was common in our patients. Of the 32 patients evaluated at the first clinic visit, 16 (53%) (who had been on HPN for a minimum of 12 months), were found to have selenium deficiency (plasma selenium level <0.8 µmol/l). The mean selenium level in these patients was 0.69 µmol/l (95% confidence limits 0.6-0.78). The mean RCGP was 11.4 IU/g haemoglobin (range 10-12.8). Of the echocardiographic parameters examined, only fractional shortening percentage (FSP), ejection fraction (EF) and mitral valve E-point-septal distance (MVEP) were shown to be useful predictors of selenium deficiency. Both FSP and EF exhibited a significant correlation (r = 0.448; p = 0.005) with plasma selenium level.

<table>
<thead>
<tr>
<th>Normal plasma selenium</th>
<th>Normal ejection fraction</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Low ejection fraction</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Low plasma selenium</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>13</td>
</tr>
</tbody>
</table>

In addition, MEVP showed a significant correlation with both plasma selenium (r = -0.46; p = 0.008) and RCGP (r = -0.46; p = 0.01).

Seventeen of 32 patients studied had subnormal ejection fraction (less than 64%) and a low plasma selenium level while 13 patients had normal ejection fraction and normal selenium.

There were only two patients who had a subnormal ejection fraction while their selenium level was normal. This gives a specificity of 87% and a sensitivity of 100% (Table 1).

Examination of the second and third clinic visit data showed that an increase in plasma selenium was accompanied by a corresponding rise in left ventricular contractility (p = 0.006).

Selenium deficiency has been regarded as a cause of heart muscle disease called 'Keshan disease' in China. The disease has a regional distribution in agricultural areas where the selenium content of the soil is reduced.5 The acute form is characterized by sudden onset of impaired heart function, whereas individuals with chronic cases exhibit moderate or severe heart enlargement with varying degrees of heart failure.6 Addition of selenium to the diet of peasants in Keshan County virtually eliminated the disease.7

Low selenium status in patients on home parenteral nutrition (HPN) has been associated with cardiomyopathy and muscle pain.7 Our findings showed that selenium deficiency is common (53%) in patients on HPN. Many of these patients have suboptimal left ventricular function. There was a significant correlation between the plasma level of selenium and both ejection fraction and fractional shortening percentage. Echocardiography appears to form a useful adjunct to the standard biochemistry assay, and in cases where a hospital does not have readily available biochemical services, echocardiography may be used as an indicator of a patient's selenium status.

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References
Transient Blindness During Pregnancy: Report of Three Cases

Sir,

Transient blindness during pregnancy is a rare phenomenon and only a few cases are reported in the world literature. Pregnancy-induced hypertension is a well-known cause of such an entity. We had the opportunity to study three cases with various aetologies during a period of 5 years out of 6500 deliveries at Al-Shaty Teaching Hospital, Jeddah.

The first case involved a 23-year-old Saudi woman, Gravida four, Parity three who had regular antenatal check-ups. When she was admitted in labour she was found to have severe fulminating pre-eclampsia, seven had renal detachment. In our third case a 17-year-old primigravida presented with acute loss of vision in both eyes of 48 h duration. She had no past history of visual or neurological complaints. Ophthalmoscopic examination showed bilateral total retinal detachment, which was successfully treated with laser therapy. She went on to term and delivered a healthy male baby.

These three cases are examples of acute emergency eye the occipital cortex which resolved completely by 7 months after delivery.

The second case involved a 30-year-old, Sudanese woman who was seen during the 30th week of gestation for deteriorating vision of 48 h duration. She had eclampsia in her previous pregnancy. She weighed 112 kg, with a blood pressure of 220/140 mmHg. Urine examination showed no proteinuria. Neurological examination was non-contributory except that vision was limited to finger counting at 6 inches, with bilateral gross papilloedema. Her MRI of brain was normal. Hence a lumbar puncture was done after control of the blood pressure was established and the opening pressure of the CSF was 430 mm of water. She was treated with hypotensives and acetazolamide and made a good recovery.

Benign intracranial hypertension is aggravated during pregnancy, occurs in obese patients, and is a totally reversible condition when it is diagnosed early and managed properly.

Partial or complete detachment of the retina has been reported during pregnancy. Of 132 cases of pre-eclampsia, seven had retinal detachment. In our third case a 17-year-old primigravida presented with acute loss of vision in both eyes of 48 h duration. She had no past history of visual or neurological complaints. Ophthalmoscopic examination showed bilateral total retinal detachment, which was successfully treated with laser therapy. She went on to term and delivered a healthy male baby.

These three cases are examples of acute emergency eye

Letters to the Editor


