Access to training in musculoskeletal ultrasound: a survey of UK rheumatology trainees

Sir, We read with interest the article by Taggart et al. [1, 2] and the accompanying editorial regarding a novel formal training programme in musculoskeletal ultrasound (MSUS). We agree that a significant impediment to training is limited access to ongoing experience despite the popularity of courses run by the British Society for Rheumatology (BSR) and other organizations.

In order to examine this in more detail we undertook a survey of UK rheumatology trainees. An invitation to complete a web-based questionnaire was sent to all trainees whose e-mail addresses were on the BSR trainee group mailing list (163 in total). All responses were anonymous: trainees were e-mailed in August 2008 with a reminder e-mail sent to non-responders.

There were 93 respondents of whom 80 were still in training and included in the analysis. Eight-two per cent were specialist registrars (SpRs) or specialty training trainees and 18% were in research posts. Fifty-five per cent of the respondents had no experience of MSUS with only 9% having what they would describe as ‘moderate’ or ‘extensive’ experience. Sixteen per cent performed MSUS regularly (half of whom were in research posts) although 47% reported that MSUS was used routinely in their department. Only 25% thought that training in MSUS was available on their rotation and 19% did not know. By the time they had completed their training, 17.5% of the respondents expected to be competent in MSUS. Twenty-six per cent had attended an MSUS course (most frequently one of the BSR courses) and a further 64% said that they intended to or may do so.

Fifty-eight per cent of those who had tried to do so had experienced difficulty in obtaining a place on a course. Fifty-two per cent reported that they had difficulty in obtaining MSUS experience in their clinical posts. Several respondents commented on the difficulty in accessing training due to pressure on radiology departments to train their own SpRs; some also commented on the perceived scepticism of radiologists that training rheumatologists was achievable. The majority of respondents (94%) thought that competency in MSUS would be advantageous to their clinical practice, and 87% thought that formal MSUS training should be part of the training programme.

These results underline the popularity of formal courses in MSUS and yet indicate limitations in access to ongoing training and experience, which is vital to acquisition of technical expertise: guidelines published by the Royal College of Radiologists recommend weekly scanning sessions for 3–6 months consisting of a minimum 250 scans [3]. The finding that only a minority of trainees thought that training was available on their rotation, and that a further group did not know what the opportunities were, indicates a need for such training opportunities to be clearly defined in the absence of a formal training programme. Ideally, this information should be available to trainees before embarking on courses that may otherwise not be backed up by practical experience. As the editorial [2] suggests, it is unlikely that we will all become competent ultrasonographers, but those who aspire to do so should have clear and predictable access to training.

Rheumatology key message

- Trainees wishing to develop skills in MSUS need to have clearly defined training opportunities.

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Ability of FRAX/NOGG guidelines to identify patients sustaining low trauma fractures

Sir, The World Health Organization Fracture Risk Assessment Tool (FRAX) enables a patient’s 10-year probability of hip fracture, and major fracture (hip, wrist, humerus and clinical vertebral) to be calculated, and is
expressed in percentage terms [1]. Guidelines written by the National Osteoporosis Guideline Group (NOGG) can then be used (in the absence of bone densitometry) to classify patients into one of the three groups: (i) those who can be treated with bone sparing therapy without the need for bone densitometry; (ii) those who should be considered for axial bone density measurement; and (iii) those who can be reassured that no further investigation or bone sparing therapy is warranted [2]. For FRAX/NOGG to be of most value, it needs to be able to reliably identify those patients who will sustain a fracture, so appropriate investigation/treatment can be instituted.

We retrospectively analysed data of 160 patients who had attended our hospital fracture clinic after sustaining a low trauma fracture, in order to calculate the proportion of these patients whom NOGG would have deemed appropriate for bone densitometry measurement or treatment with bone sparing therapy, before sustaining their fracture. Patients who were already on bone sparing therapy, who had sustained fractures of fingers, toes, face or skull and who were aged <40 years or >90 years were excluded. Post-menopausal women who had sustained fractures before incident fracture were also excluded, since NOGG guidelines recommend that these patients can be treated with bone sparing agents without the need for FRAX assessment.

The patients had a mean age (s.d.) of 67.5 (9.3) years, and 131 (82.0%) were females. The prevalence of fracture risk factors were as follows: steroid use 6.9%, smoking 18.1%, alcohol consumption ≥3 U/day 1.9%, parental history of hip fracture 5.0%, secondary cause of osteoporosis 4.4% and RA 1.9%. One hundred and five (82.0%) were females. The prevalence of fracture risk factors were as follows: steroid use 6.9%, smoking 18.1%, alcohol consumption ≥3 U/day 1.9%, parental history of hip fracture 5.0%, secondary cause of osteoporosis 4.4% and RA 1.9%. One hundred and five (65.5%) patients had no risk factors. The distribution of fractures was as follows: wrist 45.4%, ankle 14.1%, humerus 12.9%, metatarsal 9.2%, vertebral 4.3%, clavicle 1.8%, hip 1.8%, pelvis 1.2% and other 9.2%.

We then calculated the NOGG classification for each patient excluding the incident fracture. Two (1.3%) patients were classified in the ‘treat’ group, 35 (21.9%) in the ‘measure BMD’ group and 123 (76.9%) in the ‘reassure’ group. Taking only patients who had sustained a major fracture (103 patients), 2 (1.9%) were classified in the ‘treat’ group, 24 (23.3%) in the ‘measure BMD’ group and 77 (74.8%) in the ‘reassure’ group.

NOGG guidelines advocate the use of the FRAX tool only in those patients who have risk factors for fracture. Of the 55 patients who did have risk factors, NOGG would have recommended ‘treat’ in 2 (3.6%) patients, ‘measure BMD’ in 23 (41.8%) and ‘reassure’ in 30 (54.5%). NOGG classified all 29 of the men as ‘reassure’.

The distribution of fractures in our data needs to be taken into consideration when interpreting our data; just under half of the patients had wrist fractures, and there were few patients with hip or vertebral fractures included in our audit. This fracture distribution is due to the skewed nature of referrals to our fracture liaison service.

Our data show that the majority of patients would have been identified by the NOGG guideline as requiring reassurance and lifestyle advice only, immediately before sustaining a fracture. We would therefore guard against an over reliance on FRAX/NOGG in deciding which patients with risk factors for fracture to investigate or treat.

### Rheumatology key message

- Many patients who fracture would have been classified by NOGG guidelines as low risk.

### Disclosure statement

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### Rituximab as early therapy for pulmonary haemorrhage in systemic lupus erythematosus

Sir, Pulmonary haemorrhage (PH) is a rare complication of SLE with a reported frequency ranging from 1 to 5.4%, and mortality up to 92% [1]. There is general agreement that combination treatment with high-dose corticosteroids (CS) and cyclophosphamide (CYC) must be initiated early with an additional benefit with plasma exchange (PEx) shown in some small case series [2, 3]. It is important to note that, however, some studies showed no improvement in survival with early use of CYC [1] or addition of PEx [4]. Furthermore, these treatments carry the risk of significant side effects in this group of patients, particularly those with concurrent infections. Therefore, there is a real need to identify more effective treatments with fewer side effects in this group of severely affected patients. Increasingly, B-cell depletion with rituximab (RTX) has been used to treat various manifestations of SLE including secondary treatment of SLE-PH when initial therapy with CS, CYC and PEx had failed [5].