The consultation in art: Science and Charity (1897) by Pablo Picasso

Editor – On my first visit to the Picasso Museum in Barcelona, I was so taken by the life-size (197 x 249.5cm) oil on canvas painting that featured in Professor Emery’s recent Consultation in art (JRCPL September/October 2000, p485), that it prompted me to buy the museum guidebook, not only to keep as a souvenir but also as a source for background information.

According to the official museum guidebook¹, the model for the patient was indeed the beggar woman and the child her son; they were both found begging in the street, and hired for 10 pesetas.

Reference
¹ Planas CRI. Museu Picasso Guide. Barcelona: Ajuntament de Barcelona, 1998.

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In response

Editor – I am sorry that Dr Thrush is depressed by our article. Perhaps the title of the article misled him. We did not set up our single consultation clinic to save money, but to improve the management of patients. We wanted to speed up the time it took to sort out the patients, so that stroke prevention measures (particularly carotid surgery) could be started as soon as possible. We also wanted more time to talk to patients. All of these aims were achieved. The patients liked this approach, because their problems were sorted out in a single consultation.

Of course, some investigations are more cost effective than others. However, our screen was carefully chosen. Liver function tests are relevant to the investigation of stroke because they often reveal covert excess alcohol consumption, an important risk factor for stroke. Thyroid disorders are commonly missed on clinical examination, occur in about 1% of the population and hypothyroidism is associated with an elevated cholesterol and an increased risk of vascular disease. Lipid profile consisted of fasting cholesterol and triglycerides and a full profile was only performed on the blood sample if these were abnormal. There is value in everyone knowing their cholesterol level and we certainly recommend treating high cholesterol values to prevent cardiovascular and cerebrovascular events. We still screen for syphils because the disorder remains prevalent in London, but the yield is low (about one case per year). In some parts of the country it is entirely appropriate not to perform the test routinely. We found that thrombophilia was present in 4% of our patients under the age of 65 years. CT was valuable in the majority of the patients with non-cerebrovascular diagnoses.

Dr Thrush also appears to doubt the value of CT in patients with cerebrovascular disease. However, there are excellent reasons for scanning all patients with both TIA and stroke. For example, the CT result changed the management drastically in the patients who had tumours, subdural haematoma or arteriovenous malformation as the cause of their minor stroke-like or TIA-like symptoms. The finding of haemorrhage on the scan in 1% of outpatients was a contraindication to antiplatelet therapy. In those with infarcts on the scan, the distribution of the findings dictated the need for further investigation in some patients (eg echocardiography for those with cortical infarcts in both territories). The findings allowed the distinction between small vessel and thromboembolic disease, which changed the emphasis of stroke prevention measures and allowed the patient to be better informed about the cause of their problems. The finding of extensive small vessel disease indicated that anticoagulation was contraindicated.

We do not agree with Dr Thrush’s view that there is no point in carrying out carotid ultrasound unless it has been established that the patient is willing to consider carotid surgery first. This would mean counselling all patients about the potential risks and benefits of carotid surgery, wasting time and causing needless concern to the 90% of patients who do not have severe carotid stenosis. Even if the patient is known not to want surgery, the knowledge that they have severe carotid stenosis influences management. We treat such patients with combined antiplatelet therapy or
anticoagulation. Moreover, the patient can be counselled about the very high risk of recurrence and may then change their mind about surgery, especially if they have another attack.

Dr Thrush's response emphasises the need for the medical profession to be educated about the value of an active positive approach to stroke management. I hope that Dr Thrush does not need to attend a TIA clinic in the future, but if he does I hope he sees a stroke physician who properly investigates his symptoms. He would certainly be treated as an individual in a one-stop clinic, perhaps more so than in an ordinary clinic because the discussion would be focused on his particular condition, knowing the results of the investigations.

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Virus hepatitis update

Editor – I read with interest the virus hepatitis update (JRCPL July/August 2000, pp381-5). It is unfortunate that a common misconception in relation to TTV has been promulgated.

In the abstract of Professor Summerfield's update, it is incorrectly stated that TTV is a shortened form of transfusion transmitted virus. I refer to the excellent review of TTV by Yvonne Cossart, published recently in the Journal of Medical Virology1. In this, Dr Cossart quotes: ‘in May 1997 Mayumi and his colleagues in Japan identified a novel 500 bp DNA sequence in the serum of a patient during acute non A-G post-transfusion hepatitis… They named it TT virus after the initials of the index patient, but they and others have pointed out the coincidence that the initials can refer to transfusion transmitted virus.'

Reference
1 Yvonne Cossart. TTV – a virus searching for a disease. J of Clinical Virology 2000; 17:1-3.

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