Queen Mary: nobody expects the Spanish Inquisition

Three timely Offline columns by Richard Horton1–3 describe a mindless managerial rampage spreading through Queen Mary University of London, UK. Barts and The London, Queen Mary’s School of Medicine and Dentistry, has declared distinguished medical researchers to be at risk of redundancy.1 Queen Mary’s School of Biological and Chemical Sciences now follows suit.2,3 As we write, colleagues declared to be “at risk” just 2 weeks ago are summoned individually to closed audiences with the Head of School, attended by members of the ironically named “Human Resources” (HR) department. If targeted individuals fail to appease the inquisitor, they will be sacked. Other staff members are earmarked for demotion, with replacement “Teaching and Scholarship” contracts that will oblige them to desist from independent research.

But, one might ask, is it not high time to weed out slackers? It might help if one had any way of knowing who they are. Sadly, the “restructuring” hits exactly the wrong targets in many cases, and leaves unproductive academics unscathed. The reason is simple—the Head of School and HR have neither interest in, nor understanding of, individuals’ research, still less their research potential. This slaughter of the talented relies entirely on a carefully designed set of retrospective counts of the uncountable. These are labelled research “metrics”.

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the incidence of post-thrombotic syndrome in Enden and colleagues’ study, we calculate an expected absolute risk reduction in CDT patients of 4%, owing to better compliance with compression stocking use.

Furthermore, more CDT patients than non-CDT patients had good-quality anticoagulant treatment at both follow-up points. Oral anticoagulant treatment that achieves an international normalised ratio within the therapeutic range reduces the risk of post-thrombotic syndrome by 63% compared with patients who spend more than 50% of time beneath the therapeutic range. Unfortunately, time in therapeutic range was not reported in Enden and colleagues’ trial and was not accounted for in examining the effect of CDT on post-thrombotic syndrome. The CDT strategy, with its more intense treatment and hospital admission, does seem to improve outcome. However, this might not be the effect of additional thrombolysis. Instead, it could be due to more intense initial patient support, which results in more awareness of the relevance of treatment compliance. We feel that taking treatment compliance into account is important before coming to conclusions about the effect of thrombolysis on post-thrombotic syndrome and before exposing patients to costly and invasive procedures.

We declare that we have no conflicts of interest.

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Tone Enden and colleagues, in their CaVenT trial,1 explore the interesting hypothesis of catheter-directed thrombolysis (CDT) in the prevention of post-thrombotic syndrome. We have several comments.

In the Introduction section, reference was made to the updated Cochrane review2 as suggesting a benefit of systemic thrombolysis in prevention of post-thrombotic syndrome comes with the caveat that the only study with a Jadad score of greater than 3 showed no benefit.3

The CaVenT trial was done in four specialised centres, and hence the outcomes might be very different elsewhere. Additionally there might have been a learning curve for optimum results with CDT; hence it would be interesting to have a comparison of those who entered the trial earlier versus those who entered later.

Enden and colleagues do not present the bleeding rates (if any) for the control group, and hence a number needed to harm is not available. Also, the rate of stent placement and its association with outcomes would have been interesting, especially in view of scant evidence available on the topic.4

The limitations of the open-label design might have manifested with an obvious greater adherence to oral anticoagulation in the CDT group at 6 months. Finally, Enden and colleagues imply a cost effectiveness with CDT, citing the cost associated with post-thrombotic syndrome; however, it would be interesting to assess the expense associated with CDT and other indirect costs associated with the longer hospital stay necessary.

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Authors’ reply
Both sets of correspondents raise an issue about whether the noted absolute reduction in post-thrombotic syndrome of 14.4% in patients treated with additional catheter-directed thrombolysis (CDT) could be attributed to the thrombolytic treatment alone, since a higher proportion of these patients reported daily wear of elastic compression stockings and had international normalised ratios within the therapeutic range.

We agree that the non-significant tendency to better compliance could be attributable to the inherent risk of bias of this open-label randomised controlled trial, and relevance to the noted effect size cannot be ruled out. However, we think the effect on post-thrombotic syndrome cannot be simplified as suggested by Inge van Schouwenburg and colleagues. First, the two landmark studies on the use of elastic compression stockings1,2 reported on patients with any level of proximal deep vein thrombosis (DVT) from the popliteal vein and up, whereas our patients had a high proximal