The strong association between the urgency categories and time spent on the waiting list and clinical outcomes shows, on average, a high degree of clinical order. However, such implicit queuing is imperfect at the level of the individual patient; the interquartile ranges of waiting times overlapped one or two urgency categories, and a perfectly ordered queue would show no association between events while awaiting angiography and urgency category. Further investigation is required to find out how patients, general practitioners, physicians, cardiologists, and hospital managers generate a waiting list ordered by clinical need. However, if the waiting list shows some clinical order in relative terms, the length of wait in absolute terms may pose unacceptable risks. The recommended maximum waiting times for the five urgency categories, according to the Canadian panel were 3 days, 7 days, 14 days, 42 days, and 91 days, for categories 1 to 5, respectively, and a recent US study recommended that no one wait longer than two weeks.\(^1\)

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5 Rosanio S, Crook AM, Dawson R, Timmis AD, Hemingway H. The participant was a right-handed man aged 25 years preselected for scoring positively on those items of the Harvard group scale of hypnotic susceptibility dealing with ideomotor responses, motor rigidity, and inhibition of movement. An eyes-closed hypnotic induction was done, with relaxation and deepening, involving descent and special place imagery. Suggestions of left-leg paralysis were modelled on those of the previous clinical case study.\(^2\) Hypnotic depth and presence of the paralysis were monitored throughout the procedure. Before induction, neurological examination was entirely normal. After hypnotic induction and hypnotic suggestion for left leg paralysis, the participant could not move his left leg. To compare hypnotic and conversion performance, the same experimental design, statistical analysis, and PET technology were used as in the study by Marshall and colleagues.\(^1\) There was one control (no movement) and four active conditions, each done three times in randomised, counterbalanced order. The four active conditions comprised preparing to move, and attempting to move, the (good) right leg and (bad) left leg in synchrony with a metronome at 0·5 Hz. The prepare conditions involved the participant remaining ready to move immediately upon a signal, which was given only outside the acquisition time on each PET measurement. In the attempt conditions the participant tried to lift the leg. Throughout, both legs were tightly restrained to control for the absence of movement in conditions involving the paralysed leg. PET scanning used the standard oxygen-15 technique with Siemens Ecat (Siemens, Erlangen, Germany) scanner operating in 3-dimensional mode, with a total of 15 measurements of brain activity. Spatial preprocessing and statistical analysis of images was done
In our study, the anterior cingulate and orbito-frontal cortex activations probably represent neural activity responsible for inhibiting the participant’s voluntary attempt to move his left leg. Alternatively, these activations could represent the management of a mental dissonance produced when the suggestion of paralysis of the left limb conflicts with the explicit instruction to move it. Such an account would equally apply to hysterical people where the activations could reflect the management of a similarly generated internal conflict. While the first interpretation predicts that the recorded activations are specific to hypnotic or hysterical limb paralysis, the second would predict that the pattern of activation might also be seen with the same testing strategy, irrespective of the specific hysterical symptom or its hypnotically produced counterpart. Both interpretations, however, are consistent with the view that for motor paralysis, hypnosis and hysteria share similar mechanisms.

Although these are single-case comparisons, the anatomical proximity of the neural activations suggest that the psychological mechanisms which underlie hypnotic phenomena provide a versatile and testable model for understanding and treating conversion hysteria symptoms.

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Carbon-dioxide portography: an expanding role?

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We describe a new and inexpensive technique of imaging the portal vein in patients with liver disease by use of carbon dioxide.

Portal-vein thrombosis may be the cause of portal hypertension, or may complicate portal hypertension in up to 15% of patients with cirrhosis at transplantation. The presence of portal vein thrombosis has major implications with respect to patient management. Liver transplantation is contraindicated when extensive thrombosis exists, and patients with variceal bleeding are not eligible for radiological shunts. Non-invasive techniques used in the assessment of portal-vein thrombosis include: doppler ultrasound, venous phase contrast enhanced computed