We read the paper by Surash et al.\textsuperscript{1} detailing the out-of-hours vascular radiology workload in Leeds with interest. We have just completed a prospective audit of our experience in Manchester and would like to make a few comments.

Our out-of-hours emergency vascular radiology workload in Manchester appears to be many times greater than theirs in Leeds, amounting to about 200 referrals per year as opposed to their 17. We believe that Leeds have seriously underestimated their workload for the following reasons.

Firstly, Surash et al.\textsuperscript{1} only included referrals from vascular surgeons. This will under-estimate the amount of on-call work performed by the vascular radiologists. We found that vascular surgical referrals only comprised 50% of our referrals. The remainder of our cases included angiography for GI or GU tract bleeding and problems with dialysis access. In addition to angiographic procedures, the vascular radiologist was required to review CT scans when emergency endovascular repair was being considered.

Surash et al.\textsuperscript{1} have included only cases for which the radiologist was called into the hospital from home. While we agree that cases over-running, or elective cases starting after 17:00 should be considered as part of the working day, we believe that any emergency case commencing after 17:00, even if it was referred in hours, should be considered as part of an on-call service. To take this to an extreme, if the radiologist stayed to do three cases, ending at about midnight (as happened in our audit) none of these would be considered on call, according to Leeds’ criteria. There are also resource implications for paying radiographers and nurses to stay behind to do these cases. The European Working Time directive also includes telephone calls as work, although we found that only 17% of calls could be managed by advice alone.

We agree that a large proportion of these patients will require radiological intervention as part of their management (50% in our series). This means that the consultant vascular radiologist is nearly always present at the procedure and it is important to recognise that the consultant is effectively first on-call.

We believe that the volume of emergency work necessitates a Vascular Radiology on-call rota. One solution to solving the problem of staffing the on call service with sufficient numbers of experienced radiologists is to provide cross-site cover between Trusts (as advocated by the recent RCR publication\textsuperscript{2}). This model has worked effectively in Manchester for the last 5 years.

\textbf{References}


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