

New Medical Education System: Implementation of Informatic Technology and Holistic Approach Concept

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Sir, the recent report on “Quality Assessment of Medical Education at Faculty of Medicine of Sarajevo University” is very interesting (1). It is interesting that the new system seems to be challenging and can result in satisfaction of the students and outcome. Indeed, the continuous assessment of the medical education and curriculum is needed. This is according to the concept of continuous quality improvement. The updating of the necessary content (knowledge) as well as new education, teaching, techniques must be the fundamental con-

cepts. Of interest, Masic I (1) raised the importance of medical student satisfaction assessment which is usually forgotten issue. In fact, medical student can be the “client” of the Faculty and the satisfaction survey should be regularly done. However, education is not the business. Sometimes, the interpretation of satisfaction of the students has to be carefully done. Some regulations and standards must be kept. As a new medical education system, to promote the new knowledge and skill via using new tools including to the informatic technology

can be helpful. The holistic approach is required.

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Electrocardiographic Screening of Emphysema: Lead aVL or Leads III and I?

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We read with great interest the recently published study by Lazovic et al. [1]. The study reiterates a very important yet neglected ECG observation of vertical P-axis, which can be effectively utilized as a quick bedside screening modality for chronic obstructive pulmonary disease (COPD)/emphysema [2-3]. Lazovic et al. utilized unipolar lead aVL alone for vertical P-wave screening instead of bipolar leads III and I or both criteria in combination, namely P-wave amplitude in lead III greater than in lead I or a negative P-wave in aVL [2].

In one of our recent studies, we found that lead aVL is less sensitive as compared to bipolar leads III and I for diagnosing vertical P-vector in COPD patients [4]. In an ideal theoretical setting, the P wave amplitude should be negative in aVL when the P wave amplitude in lead III is greater than in lead I (suggesting vertical P vector), but

this was not found in a practical clinical setting, which could be possibly due to a commonly encountered variable/high skin resistance or poor surface contact at aVL producing a spurious “augmented” extremity (unipolar) lead abnormality. Thus, we recommend that one should consider using both leads III and I in combination with lead aVL for determination of vertical P-vector in patients with emphysema. Also, authors of this study have not specified the method employed for calculating the P-vector (automated vs. manual), but we believe they may have used automated readings to determine the correlation of P-vector with pulmonary function tests. In case when one considers to use manual P-vector readings which on some occasions may be more accurate than automated P-vectors, one would again have to use P-amplitudes in leads III and I. For these reasons,

it may be best to use all three leads (I, III and aVL) for determination of vertical P-vector while screening for emphysema, as this would offer the highest sensitivity for its diagnosis.

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