

in the interpretation of stress echocardiograms. We have been carrying on this programme for several years and I am happy to say that the level of skill of the people taking this course has been improving dramatically. In recent sessions most of the participants have been skilled at evaluating regional wall motion and their ability to interpret stress echocardiograms has been high. Thus among those individuals who have the incentive to take a course to enhance their skills there is good reason to believe that quality control is improving. Unfortunately, this experience does not tell us about the large number of physicians who do not make any effort to become trained in this technology.

There are several other possible solutions to the problem of quality control. In a hospital setting one can set rules for eligibility to interpret stress echocardiograms. Some demonstrated effort at training and or competence should be required.

Because stress echocardiograms are frequently recorded digitally, these images are easily reviewed by other physicians. This review could even be done by referring clinicians. Significant wall motion abnormalities should be apparent even to physicians who do not regularly look at echocardiograms. If the

clinicians cannot appreciate any of the changes that have been reported, they should question the accuracy of the interpretations.

The American Society of Echocardiography has begun giving competency examinations in echocardiography. Reading stress echocardiograms is a part of this examination. More tests of this type will be used to permit physicians to demonstrate their competence in echocardiography in general and stress echocardiography in particular. In the meantime, clinicians must be aware that quality control of stress echocardiography continues to be a problem. Unfortunately, quality control of almost all medical technology probably is not much better. However, the fact that echocardiograms can be performed in offices and are difficult to monitor makes the problem more troublesome. I am pleased that progress is being made. I am convinced that the quality of stress echocardiography is improving dramatically. Eventually the problem of quality control, although never eliminated, will be much less than it is today.

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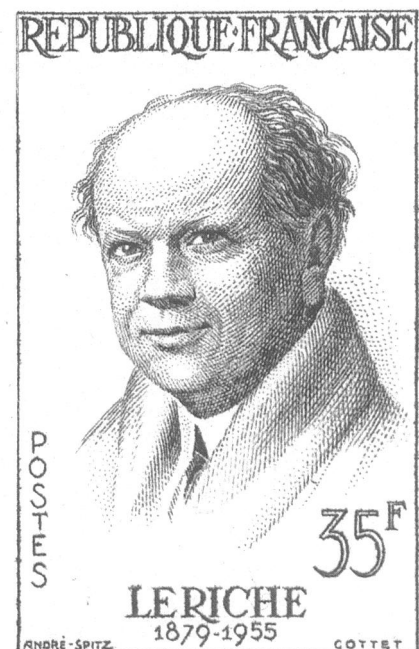
STAMPS IN CARDIOLOGY

René Henri Marie Leriche (1879–1955)

This stamp was the highest value in a set of four stamps issued by France on 25 January 1958 to commemorate famous French doctors. Recess printed, it was designed and engraved by Decaris. The other doctors featured in the set are Philippe Pinel (psychiatry), Georges Fernand Isidore Widal (microbiologist and serologist), and Charles Nicolle (bacteriologist).

René Henri Marie Leriche was an outstanding vascular surgeon who was professor of surgery in Strasbourg and Lyon before attaining the high office of Professor of the Collège de France in Paris in 1936. He is best known for his description in 1923 of the syndrome caused by incomplete obstruction of the bifurcation of the aorta which is named after him. He was an early advocate of sympathectomy for arterial disease and anticipated in the 1920s that the ideal treatment for an obliterated segment would be replacement with a vascular graft. He did in fact do several vein bypass grafts of occluded iliac arteries though without success. As this was the pre-heparin era he advised that venous allografts should not be longer than 6 cm because of the risk of thrombosis.

Leriche had a deep interest in the mechanism of pain and he pioneered the use of sympathectomy for pain relief. In 1940 he wrote a classic monograph, *La Chirurgie de la Douleur*. He was deeply admired by the British neurologist, Dr Macdonald Critchley, who said he was "a perceptive and humane doctor



... the compassionate philosopher whom the world was acclaiming in 1934 as the pain surgeon par excellence".¹

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¹ Critchley M. *The ventricle of memory. Personal recollections of some neurologists*. New York: Raven Press, 1990: 113-21.