

be made to encourage radiologists to report CT scans by grade to help in measuring the Abbreviated Injury Score (AIS) and ISS and subsequently to improve management decisions.

We routinely perform Focused Assessment by Sonography in Trauma (FAST) as part of our initial investigations. Cardiovascularly unstable patients with a positive FAST scan are protocolised to the operating theatre immediately. We have found no benefit from radiological follow-up of splenic injury, ultrasound or otherwise.

Splenic trauma is found in a minority of injured patients and our experience suggests that a high-volume centre can organise care by concentrating through-put. Whilst it is imperative that all surgeons are familiar with the indications and strategies for surgical versus conservative therapy, the management of such patients is best conducted in high-volume centres by dedicated trauma specialists and support services. Such centres provide surgical and decision-making experience for the surgical trainee.

COMMENT ON

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Targeted training for tube thoracostomy

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The article by Aylwin and colleagues rightly emphasises that tube thoracostomy is associated with a high rate of complications and is often wrongly viewed as a harmless procedure. It also recommends that junior doctors should receive further training in tube thoracostomy in addition to that imparted at the *ATLS* course¹ to reduce the complication rate. However, a recent study by Ball *et al.*² found that

general surgical trainees had the lowest rate of complications (7%) as compared to trainees from other specialties (internal and family medicine, 13%; emergency medicine, 40%). They concluded that being a non-surgical trainee was an independent predictor of complications and this was independent of the seniority of the clinician. This suggests that more structured training and close supervision is required for tube thoracostomy; however, this should be targeted to non-surgical trainees. The *Specialty Skills in Cardiothoracic Surgery course*³ conducted by The Royal College of Surgeons of England has a very comprehensive module on the safe and effective insertion of intercostal tubes; this may provide a good foundation for organising training for all junior doctors in the procedure of tube thoracostomy.

References

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2. Ball CG, Lord J, Laupland KB, Gmora S, Mulloy RH, Ng AK *et al.* Chest tube complications: how well are we training our residents? *Can J Surg* 2007; **50**: 450–8.
3. The Royal College of Surgeons of England. *Specialty Skills in Cardiothoracic Surgery: Participant Handbook*, 1st edn. London: RCSE, 2007.

AUTHORS' RESPONSE

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We welcome these comments and agree that a training programme in tube thoracostomy is required. We would argue that the 7% complication rate encountered by surgical trainees remains unacceptable, especially as these trainees insert most tube thoracostomies for trauma. The training model within the *Specialty Skills in Cardiothoracic Surgery* would appear to be a good starting point for the safe and effective insertion of tube thoracostomies and, ideally, this training should be offered to all trainees likely to be involved with chest trauma.