Figure 1 Nail cleaners

Ecouen, France] and middle [Becton Dickinson, Franklin Lakes, NJ 07417-1884, USA]) and it was not specified which one to use. We tried using the one on the left in the figure and failed to prise the nail from its bed. The pointed end cannot be used and so faces the surgeon's hand putting the surgeon at risk of self-harm if it slips during the procedure. The length of the plastic cleaner does not give an adequate lever arm. This combined with the fact that it is malleable makes the procedure difficult and the sharp tip can cause injury to the surgeon. Lastly, although the plastic cleaners come with a surgical hand-brush impregnated with a solution of chlorhexidine or PVP iodine, they are not sterile. For these reasons we do not recommend the cleaner found in hand-scrubbing packs for prising the nail. We routinely use the McDonald dissector (Fig. 1, top) for the above procedure. A long lever arm and blunt ends make it a very safe and easy to use instrument.

AUTHOR'S RESPONSE

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We use the nail cleaner found in the 'E-Z Scrub' scrubbing packs. We direct the convex surface towards the nail bed. We find avulsing the nail using this instrument to be fast and clean; we have not yet experienced any complications.

COMMENTS ON

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Role of bone scintigraphy

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We agree and compliment the authors on a comprehensive review of the literature. It has been highlighted in many articles that there needs to be a policy change in our management of suspected scaphoid fractures.

As stated in the article, bone scintigraphy and magnetic resonance imaging (MRI) are superior to repeat X-rays. MRI and bone scintigraphy are similar in diagnosing occult injuries and shortening the immobilisation. MRI has the advantage that it diagnoses ligamentous injuries.^{1,2} Bone scanning is relatively inexpensive at around £10 for the isotope. It detects occult carpal fractures other than scaphoid. Activity at fracture may correlate with prognostic features.

There are many difficulties in accessing early MRI compared to bone scintigraphy.

There has been controversy over the immobilisation of scaphoid fractures.^{3,4} This would offer an explanation for the difference in management.

Our protocol is that the suspected scaphoid patient is immobilised in a Colles backslab after negative primary scaphoid X-ray. The patient returns in 10–14 days for review by a senior accident and emergency team member in clinic. If a scaphoid fracture is still suspected, a Colles cast is used and a bone scan is performed within 3 days. Repeat X-rays are not requested. The patient is seen in fracture clinic within a week by the orthopaedic team with the bone scan results. This process has been audited and presented; it is recommended as part of a department protocol for those sites where nuclear medicine is available.⁵

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COMMENTS ON

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Whitfield AHN, Whitfield HN. Is there a role for the intravenous urogram in the 21st century? *Ann R Coll Surg Engl* 2006; **88**: 62–5

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Multidetector row computed tomography

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This article raises some important issues both clinical and non-clinical. I shall concentrate on the clinical issues here. The intravenous urogram (IVU) has for a long time been the favourite imaging test of both the uroradiologist and urologist alike. There are five principal clinical scenarios in which multidetector-row CT provides the preferred examination in most urological practice:

1. unenhanced CT for acute loin pain;
2. CT urography for investigation of haematuria when malignancy is suspected;
3. CT urography for pre-operative PCNL planning;
4. CT arteriography for assessment of living, related transplant renal donors; and
5. CT kidneys for investigation of a renal mass.

There is much supporting evidence accumulating in the literature.^{1–5} This viewpoint also has the support of the British Society of Urogenital Imaging.

The two great English stalwarts responsible for the above writing have adopted a stance reminiscent of King

Canute on the seashore. The tide is coming in fast on the IVU. Comparative studies indicate that IVU is an examination of the past without a future. My advice to the authors is to get your arm bands on fast and start swimming.

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AUTHOR'S REPLY

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The reality of urological centres dealing with emergency admissions

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I am pleased that this article has triggered a reply from such an eminent uroradiologist as Dr Cowan.

The commissioning editor had intended to include this manuscript as part of the series 'Controversial Topics in Surgery' and had tried to find an author to champion the stance taken by Dr Cowan but was unable to do so.

There are some aspects of the views advocated by Dr Cowan with which I would agree. In 1982 I was involved in a study to explore the value of CT mapping of renal stones before open nephrolithotomy.¹ Having performed more than 2000 percutaneous nephrolithotomy procedures (including track dilatation), I have not found CT mapping to be necessary. I would entirely agree that CT, combined with ultrasound, is the best imaging modality for defining the nature of renal masses.

The debate concerning the best imaging for patients with suspected renal colic cannot be resolved without