Answer: This question has been partially answered above. However, we agree routine follow-up imaging in the stable patient without clinical suspicion of bleeding is debatable. Of the 10 patients managed non-operatively that did not require splenectomy, 6 were followed up with serial ultrasound scans and 4 with repeat CT scans. Four patients who had ultrasound scans and 2 patients who had CT showed resolving haematoma and localised fluid around the spleen which subsequently resolved. None of our patients developed pseudoaneurysms or progressive haematoma.

COMMENT ON

doi 10.1308/003588408X242105

JW Moor, P Murray, J Inwood, D Gouldesbrough, C Bem. Diagnostic biopsy of lymph nodes of the neck, axilla and groin: rhyme, reason or chance. *Ann R Coll Surg Engl* 2008; **90**: 221–5

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Reducing the number of open node biopsies carried out for benign disease

PETER A BRENNAN, DUNCAN BAYNE, ELIZABETH TILLEY
Head and Neck Unit, Queen Alexandra Hospital, Portsmouth, UK

CORRESPONDENCE TO

Peter A Brennan, Consultant Maxillofacial Surgeon and Professor of Surgery, Head and Neck Unit, Queen Alexandra Hospital, Portsmouth PO6 3LY, UK. E: Peter.brennan@porthosp.nhs.uk

We read with interest this study on diagnostic lymph node biopsy, which found that 45% of cervical nodes had histologically benign disease following open biopsy. It was suggested that the level of care may be representative within many hospitals in the UK. With the increasing use of high-frequency ultrasound, combined with fine needle aspiration cytology where appropriate, the number of diagnostic open biopsies for benign lymphadenopathy should actually be very small. Nodes with worrying features on ultrasound¹ should have an ultrasound-guided fine needle aspiration or, if appropriate (e.g. suspicious for lymphoma), an open biopsy.

A review of over 300 referrals to our head and neck fast-track clinic with cervical lymphadenopathy (run jointly between maxillofacial and ENT departments) found that the number of patients who have had node biopsy, which was subsequently found to be reactive on definitive histology, was less than 8%. Almost all patients have ultrasound, some in a joint ultrasound clinic with both surgeon and radiologist present at the time of imaging. This has significantly reduced the number of open node biopsies carried out for benign disease, confirming that the results reported by Moor and colleagues might not be representative of units in the UK after all.

Reference

1. Ahuja AT, Ying M. Sonographic evaluation of cervical lymph nodes. *AJR Am J Roentgenol* 2005; **184**: 1691–9.

AUTHORS' RESPONSE

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JAMES W MOOR, CHRIS BEM
Department of Otorhinolaryngology Head and Neck Surgery,
Bradford Royal Infirmary, Bradford, UK

CORRESPONDENCE TO

James Moor, Department of Otorhinolaryngology Head and Neck Surgery, Bradford Royal Infirmary, Duckworth Lane, Bradford BD9 6RJ, UK. E: jim@docmoor.freeserve.co.uk

We thank Brennan and colleagues for their comment in supporting our conclusion that dedicated neck lump clinics will achieve a higher yield of diagnostic neck node biopsies. Our paper referred to a time when there was no dedicated neck lump clinic and when there was limited use of fine needle aspiration cytology and ultrasound scanning. It was written to illustrate the problems that arise when there are no defined pathways of care and, as we concluded, may still represent a level of care in the absence of dedicated neck lump clinics.

COMMENT ON

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JM Wilson, R Baines, ED Babu, CJ Kelley. A role for topical insulin in the management of problematic surgical wounds *Ann R Coll Surg Engl* 2008; **90**: 160

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The search for 'wound solutions'

D BAYNE
Department of Plastic Surgery, The Mountbatten Plastic Surgery Unit, Royal Hospital Haslar, Gosport, Hampshire, UK

CORRESPONDENCE TO

D Bayne, Department of Plastic Surgery, The Mountbatten Plastic Surgery Unit, Royal Hospital Haslar, Gosport, Hampshire PO12 2AA, UK. E: paperscorrespondence@inbox.com

As plastic surgeons, we are frequently referred problem wounds and sympathise with the authors' difficulties. We have had experience with the use of topically applied insulin yet, for this case, we are sceptical if it had any wound healing effect. In the after therapy photograph, the

patient's wound appears to be desloughed and cleaner revealing granulation tissue, yet is no smaller nor more epithelialised. The selection of negative pressure wound therapy (NPWT) for this case is flawed: it is recommended for post surgical abdominal wounds following debridement but not in the presence of necrotic wound eschar.¹ Furthermore the NPWT trial should be ceased if no improvement occurs after two dressing changes.¹ Although all conventional dressings in this case were unsuccessful, LarvE® are prescribable for wound debridement and their value as biosurgeons has been recognised since the napoleonic wars.² Rapid bedside debridement with Versajet® could also have been an appropriate adjunct to prepare this wound for NPWT and later skin grafting.³

The search for 'wound solutions' will continue, but the ancient principles of removal of non-viable tissue, maintaining a moist uninfected wound on a metabolically adequate patient will result in the maximal speed of wound healing.

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AUTHORS' RESPONSE

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JM WILSON, R BAINES, ED BABU, CJ KELLEY
Department of General Surgery, Hillingdon Hospital, Middlesex, UK

CORRESPONDENCE TO

JM Wilson, Department of General Surgery, Hillingdon Hospital, Pield Heath Road, Middlesex UB8 3NN, UK
E: medjmw@yahoo.co.uk

We agree that traditional wound debridement and simple dressing is sufficient for the majority of surgical wounds. Our experience with NPWT is that, although it can speed wound healing, the time period is often prolonged, patients can find it uncomfortable, and it is both costly, and requires specialist nursing input. A recently published systematic review of NPWT concluded that this modality did not offer earlier wound healing in chronic and diabetic wounds,¹ and we concur that further research into novel wound solutions, such as topical insulin, is required. Insulin application may also act synergistically with alternative strategies, such as larval debridement and honey dressings, and further clinical trials would be beneficial.

Reference

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LETTER

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Compensation claims and carpal tunnel decompression

PHILIP A STOREY, SOHAIL AKHTAR, MARY J BRADLEY, NEVILLE RM KAY, TOMMY LINDAU, FRANK D BURKE
Pulvertaft Hand Centre, Derbyshire Royal Infirmary, Derby, UK

CORRESPONDENCE TO

Philip A Storey, Pulvertaft Hand Centre, Derbyshire Royal Infirmary, London Road, Derby DE1 2QY, UK
E: phil.storey@nhs.net

Carpal tunnel syndrome is the most common upper limb diagnosis presenting to hand clinics,¹ but the number of patients making a compensation claim related to carpal tunnel decompression in the UK remains unknown.

A total of 204 anonymous, self-reported, socio-economic questionnaires were completed in 2004 by patients having undergone carpal tunnel decompression in 2000.

Of the employed patients, 7% (12/175) were involved in a compensation claim relating to carpal tunnel syndrome. This is in stark contrast to a recent similar study from the US where 38% of patients had received workers compensation.² Patients who self-reported no symptom improvement following carpal tunnel decompression were almost 5 times more likely to make a claim than patients who self-reported that their symptoms had improved (Odds ratio 4.8 [1.3–17.6]; Table 1).

Manual workers required a median of 6 weeks (IQR, 4–8 weeks) sick leave following surgery compared with 4 weeks (2–6 weeks) for non-manual workers ($n = 120$ and $n = 55$ respectively; $P = 0.001$), useful information to utilise during carpal tunnel decompression consent.

Table 1 Effect of outcome following carpal tunnel decompression on compensation claims ($P = 0.004$)

	Compensation claim		
	Yes	No	Total
Symptom improvement	8	150	158
No symptom improvement	4	13	17
Total	12	163	175