Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. Tables and figures should only be included if absolutely essential and no more than five references should be given. The editor reserves the right to shorten letters and subedit contributions to ensure clarity.

COMMENT ON

doi 10.1308/003588408X242042

PG Sorelli, NS El-Masry, PM Dawson, NA Theodorou. The dedicated emergency surgeon: towards consultant-based acute surgical admissions. *Ann R Coll Surg Engl* 2008; **90**: 104–8

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Costs of additional cover

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Sorelli and colleagues have shown that if one employs an extra general surgeon then more of the emergency admissions will be operated upon more quickly and their length of stay in hospital will be reduced, thereby improving their quality of care. However, the savings of £90,000 per annum must be set against the cost of the additional surgeon. The additional surgeon is being employed from 9 am until 5 pm, five days a week. If it is on ten programmed activities (PAs), he or she will only be available for emergency care three and a half days a week, so to cover the rest of the time, vacation and study leave, one imagines that Imperial College will actually have to employ two consultants or alternatively pay the additional consultant 12.5 PAs per week to work 9 am until 5 pm, Monday to Friday. The consultant's salary will, therefore, be considerably greater than the £90,000

saved by reduced in-patient stay. There is absolutely nothing wrong in employing extra staff to improve patients' quality of care; however, this would generally be associated with increased expenditure, as in this case.

COMMENT ON

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S Sinha, SVV Raja, MH Lewis. Recent changes in the management of blunt splenic trauma: effect on splenic trauma patients and hospital implications. *Ann R Coll Surg Engl* 2008; **90**: 109–12

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Blunt splenic trauma

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Since January 2004, 105 patients (2.5% of total trauma admissions) were seen having suffered splenic injury; of these, 85 (81%) suffered blunt injury. Mortality was 19% patients (20 of 105). The overall median Injury Severity Score (ISS) was 35. Fifty-five patients had a laparotomy (52%). The total number of splenectomies performed was 34 (a rate of 32%) and the median ISS in this group was 40. Of the patients who survived, 24 had a splenectomy and 16 had a laparotomy and splenic preservation surgery (packing, spleen seen to have stopped bleeding and requiring no intervention). Ten of the patients who died had a splenectomy and 5 had a laparotomy and the spleen was preserved. The median ISS in the group treated conservatively was 27. Only 4 patients had an isolated splenic injury. Five patients underwent splenic artery embolisation with good effect.

The high ISS in those undergoing splenectomy re-emphasises the surgical dilemma of whether or not to attempt preservation of the damaged spleen in light of injuries to other body regions.

The paper highlights the problem with splenic injury grading from CT scanning and we feel that further efforts should

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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CJ Aylwin, K Brohi, GD Davies, MS Walsh. Pre-hospital and in-hospital thoracostomy: indications and complications. *Ann R Coll Surg Engl* 2008; **90**: 54–7

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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

1. American College of Surgeons. *Advanced Trauma Life Support*, 7th edn. Chicago, IL: ACS, 2005.
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.