AUTHORS' RESPONSE 3

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The suggestion by Khan and colleagues that senior trainees should be formally required to train juniors as part of their own training requirements is an interesting one. This would certainly help to balance the training opportunities between junior and senior trainees, but more detail would be required as to how this would work in practice. With the increasing pressures placed on junior trainees by hospital-at-night, we believe that ring-fenced training opportunities should be identified. Moreover, there should be a formal recognition of contractual time for consultants to train junior surgeons. These aims could be addressed by having dedicated training lists for juniors on a weekly basis.

COMMENT ON

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R Cowen, T Richards, A Dharmadasa, A Handa, JMT Perkins. The acute blue finger: management and outcome. *Ann R Coll Surg Engl* 2008; **90**: 557–60

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Acute blue finger – not always benign

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We read with interest this article but would disagree with the authors' comments on acute blue finger being a 'benign' condition without threat to limb or digit loss and that arterial imaging studies, therefore, are unnecessary. It has been our experience that the acute blue finger not infrequently progresses to an acute black hand with subsequent digit/limb loss.

We have recently seen a patient who presented with acute blue discolouration of all the finger tips of her left hand with associated pain. She had a completely normal arterial examination, blood tests (including rheumatological and immunological), cardiac investigations and radiographs. Initial angiography was reported as normal. She underwent a left cervical sympathectomy for symptom control but returned a month later with pre-gangrenous changes to the fingertips and intractable pain. Repeat angiography revealed a stenosis at the origin of the left subclavian artery necessitating an endarterectomy. Four months later, after the finger tips had demarcated, all four distal phalanges were amputated with good functional results.

We, therefore, suggest that acute blue finger should not be viewed as a benign condition and warrants full investigation as it may be a prelude to major arterial embolisation.

COMMENT ON

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HA Anwar, QA Ahmed, HA Bradpiece. Removing symptomatic gallstones at their first emergency presentation. *Ann R Coll Surg Engl* 2008; **90**: 394–7

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Timing of surgery for symptomatic gallstones

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I read this paper on the timing of surgery for symptomatic gallstone disease with interest. However, based on the data presented, I think the conclusions reached must be greeted with caution. If patients, particularly presenting with acute cholecystitis, were informed that they could be discharged to return for a day-case laparoscopic procedure or they could remain as an in-patient for an average of 5 days before having an operation that would have a significantly higher change of being converted ($P = 0.007$, Fisher's exact test) with a longer postoperative stay (data not given), I wonder how many of them would choose the latter option? Equally, it is difficult to see how a robust business case could be made to hospital managers to support the recommended treatment plan.

Although it is clearly undesirable for patients to have to wait 5 months for an interval operation, with the associated risks of suffering from further symptomatic episodes, there