are alternatives to remaining an in-patient for surgery on an emergency list. For example, these patients can be discharged home once their symptoms have settled, with a date for a laparoscopic cholecystectomy within a month, on a dedicated (potentially day-case) 'hot gallbladder' list.

COMMENT ON

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A Rafee, D Herlikar, R Gilbert, RC Stockwell, GJ McLauchlan. D-Dimer in the diagnosis of deep vein thrombosis following total hip and knee replacement: a prospective study. *Ann R Coll Surg Engl* 2008; **90**: 123–6

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Another nail in the coffin for role of D-dimer in diagnosis of postoperative deep vein thrombosis!

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The authors must be commended on their elaborate effort to prove the futility of D-dimer testing in postoperative patients. Innumerable studies have been done to try and prove the usefulness of D-dimer testing along with pre-test probability score, all aimed at avoiding expensive imaging.^{1–3} The study could have been more meaningful if they had clarified the following issues:

1. The specificity and sensitivity of D-dimer levels vary with the type of test—enzyme-linked immunofluorescence assay (ELFA), microplate enzyme-linked immunosorbent assay (ELISA) or latex quantitative assay; the authors have not mentioned which test type did they use.⁴
2. In the historical controls, only 37% patients had deep vein thrombosis (DVT) on or before day 7 after joint replacement surgery. The assessment of D-dimers pre-operatively and on postoperative days 1, 3, 5, 7 and duplex imaging on day 7 would have missed out a major proportion of patients likely to develop DVT (up to 63%). Considering the fact that the authors first presented this work in 2005, follow-up data on these 78 patients, if available, could have made the present publication more meaningful.
3. The value of day 1 D-dimer in the published abstracts^{5,6} of their presentations is 3.63 compared to 3.39 in the present article, without any obvious change in any other numbers, probably a typing error in the present article.

D-Dimer should remain as a screening test for proximal DVT and pulmonary embolism for out-patients with low clinical probability of DVT, where it obviates the need for a duplex ultrasound examination. Positive D-dimer, irrespective of its value, has little meaning when the probability of clinical DVT is high.

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COMMENT ON

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WD Beasley, CP Gibbons. Cranial nerve injuries and the retrojugular approach in carotid endarterectomy. *Ann R Coll Surg Engl* 2008; **90**: 685–8

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Points for clarification

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I read this paper with interest and congratulate the operating surgeon on his low cranial nerve injury rates. I would be grateful for clarification regarding the following issues. Why were there 225 exclusions? Did the cranial nerve injuries occur early in the series or late and were they the reason for the stated change in approach? What is meant by 'targeted follow-up' and how long did the injuries take to resolve (*i.e.* was this a reflection of the effect of local anaesthetic infiltration or tension neuropraxia)? Why was the chi-squared test used for such small numbers of complications?