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/submissions/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.

Testing the distal tibiofibular syndesmosis – comment 3

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The intra-operative diagnosis of syndesmotomic ligament rupture is problematic. Neither plain radiography¹ or clinical testing is completely reliable.^{2,3}

As the authors point out, fibular translation in the coronal plane correlates poorly with diastasis when using the hook test. Candal-Couto *et al.*⁴ demonstrated that translation in the sagittal plane was more significant than movement in the coronal plane after sequential division of the three syndesmotomic ligaments in the cadaveric model (8.8 mm vs 1.5 mm). This suggests that intra-operative anteroposterior stressing rather than mediolateral stressing with the hook is a more sensitive test of syndesmotomic failure. Why then do the authors advocate testing their technique in the coronal plane?

A further point of note is that this technique of pushing the tibia medially away from the fibula along the 3.5-mm tap will rely upon the patient having sufficient bone quality. In the osteoporotic patient, the tap may subside into the lateral cortex of the tibia and/or lose grip in the fibula, thus preventing analysis of the syndesmosis.

If one wished to stress the syndesmosis in the sagittal plane with this technique, movement would be limited (and the surgeon falsely re-assured) by contact with the tip of the 3.5-mm tap against posterior aspect of the anterior tibial tubercle. Perhaps if the tap was inserted flush with the medial cortex of the fibula then stressed in the sagittal plane, the technique would be more reliable?

References

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Use of inner versus outer wall for assessing abdominal aortic aneurysm size

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COMMENT ON

Thapar A, Cheal D, Hopkins T, Ward S, Shalhoub J, Yusuf SW. Internal or external wall diameter for abdominal aortic aneurysm screening? *Ann R Coll Surg Engl* 2010; **92**: 503–505.
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We read the article by Thapar *et al.* with interest and have a number of concerns regarding the methodology used in their study.

From the article, it is not clear whether the clinical vascular scientists who took part were formally trained in the two methods of aorta/aneurysm diameter measurements. If the vascular scientists had a preference for one method of measurement in their routine practice, then this would bias the outcome of their measurements. Sonographers in the NHS Abdominal Aortic Aneurysm Screening Programme (AAASP) undergo formal training and the issue of placement of measurement calipers (particularly in identifying thrombus where confusion can arise) is carefully addressed. Therefore, it would be more valid if

the sonographers in this study had been compared with those fully accredited by the NHSAAASP.

We also have concern about the capture of the image used in Figure 2, given by the authors as an example of ultrasound diameter measurement. This image would fail the quality assurance requirements of the NHSAAASP with particular respect to the excessively high gain used at the posterior wall of the aneurysm. This makes it almost impossible to identify either the outer or inner wall.

There is currently much debate on which method of AAA measurement is more reliable. We feel that effort should be made to ensure that correct methodology is used before discrediting one or the other method.

AUTHORS' RESPONSE

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We undertook a pilot study to quantify the differences between using internal and external wall diameter measurements in the context of aortic aneurysm screening.

1. Screening sonographers are required to perform 100 aortic scans and, of these, 25 supervised (NHSAAAP Technician's Log Book). We accept the study sonographers were not NHSAAAP accredited. However, the sonographers in the study have a registered degree from the Society for Vascular Technology, their ultrasound measurements are regularly audited against CT, and they perform around 300 aortic scans each per year.
2. Our sonographers found an increased variability in internal wall measurements. It is important that screening sonographers are taught about the problems of luminal thrombus which can make internal wall measurements problematic.
3. We accept the gain in Figure 3 is high. The image is not part of the study series (the external diameter is 92 mm whereas the largest aneurysm in the series was 78 mm). It is a good illustration of how luminal thrombus can introduce a large degree of subjectivity to the internal wall diameter measurement.

The early stages of the NHSAAAP provides the ideal opportunity to audit internal and external wall variability, with large numbers of patients and independent offline image analysis for quality assurance.

Evolving posters

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'Unfortunately your posters were put on the wrong aircraft. We can have them returned to the UK tomorrow and then on to Switzerland later in the week.' Calming words from a nameless 'no frills' airline, but not much help to me and my posters due for presentation in Lausanne last year. I am not the first person that this has happened to, but perhaps I should be the last.

I am not averse to posters – far from it – they are a great medium for surgical and scientific presentation.¹ But as good as posters are – let's face it, they can be a bit of an ordeal. First they require organising weeks in advance of the meeting so as to allow time for printing and laminating prior to departure. This is not only a time consuming exercise but also expensive and environmentally unfriendly. The next potential difficulty is how to transport said poster on a commercial flight. Can it be rolled so tightly as to fit into a large suitcase (and risk creases) or will it require a poster tube that may not even be allowed into the aircraft cabin if the CAA have their way? If it is deemed too dangerous to accompany you in the cabin, it will be demoted to the aircraft hold with the chance that you may never see it again. I once had a poster tube so large it was never allowed inside the aircraft cabin. It was good in that the redundant inside space could be filled with extra clothes but, rather embarrassingly, it was mistaken for a missile launcher at Heathrow and a set of golf clubs in Brisbane! Having miraculously made it safely to the conference, your poster will require unfurling and hanging. This can be quite a challenge single-handed and often requires the help of other poster hangers or hangers-on. Getting the curl reversed is a skill in its own right. And have you brought the correct drawing pins/Velcro/staples to stick the thing up?

It could all be so much easier if posters, well, weren't posters.

Earlier in the month, I attended the Royal Australian College of Surgeons' Annual Meeting in Perth where posters had been replaced with e-posters. This was not the first conference where I have seen e-posters, but it seemed to work well for what was a large surgical meeting of over 1500 delegates. There were two sections in the main exhibit area designated to 'e-posters' where four wide-screen monitors were used to allow delegates to click and choose the posters they wished to view. Posters were viewed as a single PowerPoint slide. The e-posters seemed very popular at the meeting with