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

presenters and delegates alike, the only detraction being the lack of author/delegate discussion.

At some meetings, it is often possible to set aside time specifically for poster presentations to be 'presented' in shorter form.² At the European Plastic Surgery Research Council last August, this worked very well as an informal early evening social event. In the relaxed setting of an evening drinks reception each of the posters were briefly presented (three slides maximum) and discussion flourished (in some cases long into the evening).

e-Posters can be educationally and scientifically sound. They can allow the author and conference delegates the opportunity to discuss the science of surgery to the full with minimal organisational and transportation issues. e-Posters are green and portable – nowadays who doesn't travel with a USB-drive tucked in their pocket? Poster presentations are an essential element to scientific surgical meetings as they allow all members of the surgical team an opportunity to present their work. We should embrace them as an opportunity to present quality research, but they should evolve much like the science of surgery.

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***Clostridium difficile* knowledge in healthcare workers: conclusions in the absence of broader evaluation**

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COMMENT ON

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A validated, knowledge-based questionnaire tool could provide the means for identification of risk factors associated with poor levels of knowledge, assist in targeting educational interventions, and provide measurable data on the impact of educational interventions.

Unfortunately, Aroori *et al.* failed to examine if data resulting from the questionnaire could discriminate populations with known differing levels of knowledge or if conclusions were valid in repeated sampling of healthcare

worker populations elsewhere. Additionally, the questionnaire provides no clear conclusion/definition of what is an adequate level of knowledge, *i.e.* does anything less than 100% correct response deem a healthcare worker as possessing a lack of knowledge?

Previously, we assessed methicillin resistant *Staphylococcus aureus* knowledge in healthcare workers, both in a surgical trainee¹ and wider healthcare worker population in repeated sampling. We found questionnaire statements on policy could be UK-region specific and that knowledge levels needed to be judged against a broader healthcare worker population context. In addition, even populations with assumed high levels of knowledge (infection control nurses) did not achieve 100% correct answers.²

Until further validation, it is difficult to support the conclusions that the study findings are indeed 'valid' in reference to a presumed 'significant lack of knowledge' in wider consultant and nursing staff populations.³ This questionnaire can only ultimately comment on a local population, sampled at a specific time, and does not adequately define an appropriate level of knowledge.

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AUTHOR'S RESPONSE

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We would accept that any survey of this kind can only reflect the knowledge of those within the population which was sampled at the time the sample was taken. Indeed, it is very likely that awareness of *Clostridium difficile* is greater now than it was then. Nevertheless, it does give some insight into the understanding of these issues within different groups of healthcare workers.

No precise definition of 'adequate' levels of knowledge has been attempted. It would be a separate study to compare 'knowledge' with 'practice' (which is what really matters) to define the minimum level of knowledge for the delivery of good practice.