Letters and comments

The role of the chest x-ray for the acute abdomen in the 21st century

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COMMENT ON

Alazzawi S, Sprenger De Rover W, Morris-Stiff G, Lewis MH. Erect chest radiography in the setting of the acute abdomen: essential tool or an unnecessary waste of resources? *Ann R Coll Surg Engl* 2010; **92**: 697–699
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This paper raised some important points. First, it is not possible to conclude that the majority of chest x-rays (CXRs) performed on patients admitted on a surgical intake with abdominal pain are not necessary; in this study, 96% of CXRs were requested to exclude a perforation and 3% to investigate respiratory signs on examination. As such, 99% of CXR requests satisfied the current guidelines on requesting a CXR in patients with abdominal pain.

Second, no description of the clinical outcome of patients with a normal CXR is given. It may be that the presence of a normal CXR allows the early discharge of patients. Further, without a normal CXR, it seems likely that more patients would have received cross-sectional imaging, which would mean a greater burden on resources and cost as well as a greater dose of radiation for patients. In this series, 23% of patients had positive radiological findings (7% with new findings and 16% with old findings) and a 'pick up' of 1 in 5 is acceptable for a simple and cheap diagnostic test.

It is not clear which grade of surgeon ordered the CXR or indeed which department. In a similar audit in our department of 181 patients admitted with acute abdominal pain over a 4-week period in April 2010, 113 patients (62%) received a plain CXR. Sixty-nine (61%) had the CXR ordered from the emergency department (ED) rather than within our department and a normal CXR for ED patients may also have facilitated discharge rather than referral and admission.

We should be clear about the other diagnostic options or advocate senior surgical review prior to the ordering of investigations before writing off the erect CXR as a diagnostic tool altogether.

Hand-held device for smoke extraction

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COMMENT ON

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I was interested to read the technical tip by King and Ferguson on a cheap and effective method for smoke evacuation. Almost a decade ago, while working at the plastic surgery unit in Bristol, I was introduced to the same technique, which was eventually abandoned in favour of a modification. By incising the suction tubing twice (with a 15 blade) the diathermy blade could be fed 'in and out' (Fig 1) so that it no longer protruded from the lumen. Our experience was that the modification made the smoke evacuation more effective (presumably as less of the lumen was occluded by the diathermy blade). In addition, by altering the distance between cuts, the surgeon can vary the length of blade to be exposed (while the rest remains insulated within the lumen), conferring greater precision and safety if operating in confined areas.

I recommend the modified technique to King and Ferguson.

Figure 1 Diathermy blade fed into and out of tube lumen