imise the benefit to the patient with the minimum number of steps in the process. The case for CHO perioperative drink is not settled and should not become established as dogma (which applies to any other step in the process) until it is proven.

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A case of reflective evidence-based surgery

D Nikkhah

University College London, UK

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CORRESPONDENCE TO

Dariusz Nikkhah, E: dariushnikkhah@hotmail.com

A fellow colleague in the emergency department consulted me for advice regarding a two-year-old child with a facial laceration. The child had had a simple fall against a wooden table and sustained a 3cm clean linear laceration in the intercanthal area. My colleague asked me whether glue would be a better idea than suturing. I replied that the cosmetic outcome with suturing was far superior and that one would avoid the risk of dehiscence. My reply was based on anecdotal evidence from other colleagues and senior surgeons. This doctor followed my advice and the child had her wound sutured under general anaesthesia with no complications.

I later thought to myself that there should be a body of evidence to support or refute my advice on this particular issue. I knew that strong evidence such as a randomised controlled trial (RCT) would answer this question. I performed a MEDLINE® search expecting a paucity of evidence; instead I was greeted with a Cochrane review and a number of prospective RCTs.¹ I discovered that suturing conferred no benefit in terms of cosmesis in the paediatric population but that there was a statistically significant increased risk of dehiscence. This level 1 evidence has changed my practice. With hindsight I would explain this evidence to the parents and offer the option of glue. Indeed, the glue technique would obviate the risks of general anaesthesia and a hospital stay.

As surgeons, we can only be effective if we question our practice daily. We should always endeavour to practise research to strive for the truth as this will improve patient care. Evidence-based practice can save our hospitals money and time, particularly in a period of such financial upheaval.

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Caliper measurement to improve assessment of neck lumps

Comment 1

Although this comment was published originally in the September 2012 issue of the *Annals*, we omitted to publish the author's response alongside it. We include Mr Wasson's response below and apologise for any inconvenience caused.

P Brennan

Portsmouth Hospitals NHS Trust, UK

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CORRESPONDENCE TO

Peter Brennan, E: peter.brennan@porthosp.nhs.uk

COMMENT ON

Wasson J, Amonoo-Kuofi K, Scrivens J, Pfeleiderer A

Caliper measurement to improve clinical assessment of palpable neck lumps. *Ann R Coll Surg Engl* 2012; **94**: 256–260

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I read the above paper with interest. It is certainly an easy-to-use technique to monitor the size of readily palpable lumps that are seen by head and neck specialists and it would seem to increase the accuracy of clinical measurement. However, I was concerned that the authors stated that as a result of increasing numbers of referrals, not all new patients with a palpable neck lump will go on to have ultrasonography and that calipers can improve clinical assessment, particularly when an ultrasonography machine is not available.

They also mentioned that all patients with a lump greater than 9mm in their unit will go on to have ultrasonography. The authors make no mention of what the upper limits of normal size for lymph nodes are in various levels of the neck; these vary depending on site. For example, a 15mm jugulodigastric node with a short axis on ultrasonography less than 9mm may well be reactive while a similar size node in the submental area is almost always pathological and requires fine needle aspiration to exclude malignancy.¹

The additional advantage of ultrasonography is that it can confirm a reactive node at the first visit not only by short axis measurement but also by demonstrating normal hilar architecture and blood flow using colour flow Doppler. None of these assessments can be made using clinical examination or calipers and, consequently, patients having clinical assessment alone will undoubtedly be followed up in a review clinic instead of being reassured and discharged.

Therefore, perversely, not having access to ultrasonography may result in additional clinic visits as well as potentially delaying a malignant diagnosis irrespective of better accuracy in determining the lymph node size using calipers. In addition to diagnosing metastatic disease, lymphoma