

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.

References

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A case of reflective evidence-based surgery

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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.

Reference

1. Farion K, Osmond MH, Hartling L *et al*. Tissue adhesives for traumatic lacerations in children and adults. *Cochrane Database Syst Rev* 2002; **3**: CD003326.

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.

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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

nodes (which in certain subtypes can remain small for some time) often have readily visualised ultrasonography appearances and rapid diagnosis can be made using ultrasonography guided tru-cut biopsy.²

Finally, the authors make no mention of oral and maxillofacial surgeons managing neck lumps. In many units in the UK, both otolaryngologists and oral and maxillofacial surgeons work together to provide a high quality neck lump service with a head and neck radiologist; many patients can be discharged at the first visit following clinical assessment and ultrasonography.

References

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2. Vandervelde C, Kamani T, Varghese A *et al*. A study to evaluate the efficacy of image-guided core biopsy in the diagnosis and management of lymphoma – results in 103 biopsies. *Eur J Radiol* 2008; **66**: 107–111.

Comment 2

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I read with interest the article by Wesson *et al* and would like to respond to the authors' conclusion that 'Caliper measurement is more accurate than clinical palpation'. I fail to understand why research is needed with concurrent waste of time, effort and resources to establish something that is so obvious.

Author's Response

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While our paper confirms the obvious assumption that caliper measurement is more accurate than clinical palpation, it also highlights that caliper measurement is statistically comparable with accurate ultrasonography measurement for clinically palpable neck lumps. We therefore emphasise the merit of this inexpensive adjunct in assessing neck lump size when more expensive tools are not immediately available.

Our study highlights the use of calipers in augmented clinical assessment at neck lump clinics. As previously discussed, we acknowledge that calipers cannot substitute ultrasonography in the assessment of lump morphology, vascular flow and anatomical origin or targeting for fine needle aspiration. We also appreciate that different nodal levels have varying acceptable sizes for normality. Suspicious lymph nodes with a minimal axial diameter greater than 10mm (15mm for junctional nodes) have a sensitivity and specificity of approximately 70% for neoplastic involvement.¹ For this reason, all neck lumps greater than 9mm in size are selected for ultrasonography assessment in addition to smaller neck lumps with a high index of clinical suspicion for neoplastic involvement.

All data were obtained in an ear, nose and throat neck lump clinic. This is why oral and maxillofacial surgeons were not mentioned in the paper. However, we fully acknowledge that head and neck cancer management is a multidisciplinary effort to which oral and maxillofacial surgeons provide an invaluable contribution.

Reference

1. ENT UK. *Head and Neck Cancer: Multidisciplinary Management Guidelines*. 4th edn. London: ENT UK; 2011.