

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.<sup>2</sup>

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

1. van den Brekel MW, Castelijns JA, Snow GB. The size of lymph nodes in the neck on sonograms as a radiologic criterion for metastasis: how reliable is it? *Am J Neuroradiol* 1998; **19**: 695–700.
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

### G Alex

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### CORRESPONDENCE TO

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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

### J Wasson

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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 augmenting 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.<sup>1</sup> 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.