However, we are concerned that the authors have totally ignored the impact that a full clinical assessment would have on correct diagnosis. We feel strongly that radiological techniques are an adjunct, albeit important, to clinical history taking and examination in the formulation of a working diagnosis. In this way, the majority of patients may be correctly diagnosed pre-operatively, which ought to be the minimum standard.

Author's Response

Jonathan Weir-McCall, E: jweirmccall@doctors.net.uk
doi: 10.1308/003588412X13373405386330

We thank the authors for their interest in our article and are interested to hear that our findings correlate well with that of their own experience. We did not intend to discount the effect of clinical judgement and indeed the study was not designed to assess this, as it did not include patients who never required CT, or those who had CTs but never required operative intervention.

The accuracy of clinical judgement and the effects of CT on this have been well documented elsewhere.[1] The purpose of the study was to quantify the degree of confidence surgeons could place in the CT findings when they are considering operative intervention. The role of CT being an adjunct rather than the decisive factor in decision making was well demonstrated in our study as 11% of patients with inaccurate reports progressed to have a non-exploratory operative intervention. Our study showed that only 3% of patients had a negative laparotomy, which is surely the best indicator that by working as a team surgeons and radiologists can come to a very accurate decision of when operative intervention is necessary.

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Caliper measurement to improve clinical assessment of palpable neck lumps

Peter Brennan
Queen Alexandria Hospital, Portsmouth, UK
doi: 10.1308/003588412X13373405386178

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

COMMENT ON
Wasson J, Amonoo-Kuofi K, Scrivens J, Pfleiderer A
Caliper measurement to improve clinical assessment of palpable neck lumps. *Ann R CollSurgEngl* 2012; **94**: 256–60

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 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 an ultrasound and that calipers can improve clinical assessment, particularly when an ultrasound machine is not available.

They also mentioned that all patients with a lump greater than 9mm in their unit will go on to have an ultrasound. 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 ultrasound 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 cytology to exclude malignancy.[1]

The additional advantage of ultrasound 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 therefore 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 ultrasound 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 ultrasound appearances and rapid diagnosis can be made using ultrasound guided trucut biopsy.[2]

Finally, the authors make no mention of oral and maxillofacial surgeons (OMFS) managing neck lumps. In many units in the UK, both ENT and OMFS 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 ultrasound.

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