Answer: This question has been partially answered above. However, we agree routine follow-up imaging in the stable patient without clinical suspicion of bleeding is debatable. Of the 10 patients managed non-operatively that did not require splenectomy, 6 were followed up with serial ultrasound scans and 4 with repeat CT scans. Four patients who had ultrasound scans and 2 patients who had CT showed resolving haematoma and localised fluid around the spleen which subsequently resolved. None of our patients developed pseudoaneurysms or progressive haematoma.

COMMENT ON

doi 10.1308/003588408X242105

JW Moor, P Murray, J Inwood, D Gouldesbrough, C Bem. Diagnostic biopsy of lymph nodes of the neck, axilla and groin: rhyme, reason or chance. *Ann R Coll Surg Engl* 2008; **90**: 221–5

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Reducing the number of open node biopsies carried out for benign disease

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We read with interest this study on diagnostic lymph node biopsy, which found that 45% of cervical nodes had histologically benign disease following open biopsy. It was suggested that the level of care may be representative within many hospitals in the UK. With the increasing use of high-frequency ultrasound, combined with fine needle aspiration cytology where appropriate, the number of diagnostic open biopsies for benign lymphadenopathy should actually be very small. Nodes with worrying features on ultrasound[1] should have an ultrasound-guided fine needle aspiration or, if appropriate (e.g. suspicious for lymphoma), an open biopsy.

A review of over 300 referrals to our head and neck fast-track clinic with cervical lymphadenopathy (run jointly between maxillofacial and ENT departments) found that the number of patients who have had node biopsy, which was subsequently found to be reactive on definitive histology, was less than 8%. Almost all patients have ultrasound, some in a joint ultrasound clinic with both surgeon and radiologist present at the time of imaging. This has significantly reduced the number of open node biopsies carried out for benign disease, confirming that the results reported by Moor and colleagues might not be representative of units in the UK after all.

Reference

1. Ahuja AT, Ying M. Sonographic evaluation of cervical lymph nodes. *AJR Am J Roentgenol* 2005; **184**: 1691–9.

AUTHORS' RESPONSE

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We thank Brennan and colleagues for their comment in supporting our conclusion that dedicated neck lump clinics will achieve a higher yield of diagnostic neck node biopsies. Our paper referred to a time when there was no dedicated neck lump clinic and when there was limited use of fine needle aspiration cytology and ultrasound scanning. It was written to illustrate the problems that arise when there are no defined pathways of care and, as we concluded, may still represent a level of care in the absence of dedicated neck lump clinics.

COMMENT ON

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JM Wilson, R Baines, ED Babu, CJ Kelley. A role for topical insulin in the management problematic surgical wounds *Ann R Coll Surg Engl* 2008; **90**: 160

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The search for 'wound solutions'

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As plastic surgeons, we are frequently referred problem wounds and sympathise with the authors' difficulties. We have had experience with the use of topically applied insulin yet, for this case, we are sceptical if it had any wound healing effect. In the after therapy photograph, the