

Letters and comments

Hip fractures: public perceptions – are we jumping the gun?

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COMMENT ON

McBride TJ, Panrucker S, Clothier JC

Hip fractures: public perceptions. *Ann R Coll Surg Engl* 2011; **93**: 67–70
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We read with interest the article by McBride *et al*, which reported that only 4% of 127 patients and relatives in an out-patient clinic post hip replacement following a hip fracture correctly acknowledged one-year mortality for hip fractures to be approximately 30%. Poor knowledge retention of doctor–patient consultations (20–60%)¹ does not explain this figure fully.

To investigate further we undertook a retrospective review of case notes for patients presenting with hip fractures during the period July to August 2011, searching for evidence that patients and their relatives were being given information on morbidity and mortality. Written documentation was only found on 10 occasions (28.6%). Although the risks and benefits of surgery are discussed with the patient, it would seem that the severity of the injury itself is not communicated adequately. This might explain why the public grossly underestimates the mortality of sustaining a hip fracture.

Discussing such sensitive issues in the acute setting can be very distressing for both the patient and the doctor but it is important to discuss the diagnosis itself to avoid creating unfair and unrealistic expectations of treatment. Perhaps an information leaflet should be incorporated into current hip fracture pathways?

Reference

1. Kessels RP. Patients' memory for medical information. *J R Soc Med* 2003; **96**: 219–222.

Authors' response

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doi: 10.1308/003588412X13373405386376

The audit undertaken by Weston *et al* highlights very nicely the lack of emphasis on spending time talking to patients and relatives regarding the serious nature of hip fractures. Since publishing my work on the public perceptions of hip fractures I have endeavoured to make time for such explanation when dealing with this patient group, especially in those patients who are cognitively impaired. I have also made it a priority to attempt to educate junior orthopaedic staff on this matter.

It still surprises me that most hospital trusts do not include written information on hip fractures within the care pathway. A section or tick box in the pathway to document discussion on this matter with the patient and relatives would also be helpful.

The use of pre-operative computed tomography in the assessment of the acute abdomen

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COMMENT ON

Weir-McCall J, Shaw A, Arya A, Knight A, Howlett DC

The use of pre-operative computed tomography in the assessment of the acute abdomen. *Ann R Coll Surg Engl* 2012; **94**: 102–107
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The authors have presented a study correlating the reports of abdominal computed tomography (CT) in the acute abdomen with findings at laparotomy. The retrospective diagnostic 'accuracy' of CT scan reporting rises from 78% when reported by a registrar to 85% when additionally assessed by a consultant and finally to 95% after a further consultant review. In their conclusions, the authors state that this represents 'a high degree of accuracy'. This mirrors our experience: we also feel that the correct diagnosis is missed by CT scan in approximately one to two patients in every ten presenting with an acute abdomen requiring surgery.

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

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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.

Reference

1. Tsushima Y, Yamada S, Aoki J *et al.* Effect of contrast-enhanced computed tomography on diagnosis and management of acute abdomen in adults. *Clin Radiol* 2002; **57**: 507–513.

Caliper measurement to improve clinical assessment of palpable neck lumps

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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**: 256–60

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 tru-cut 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.

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? *AJNR 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.