are alternatives to remaining an in-patient for surgery on an emergency list. For example, these patients can be discharged home once their symptoms have settled, with a date for a laparoscopic cholecystectomy within a month, on a dedicated (potentially day-case) ‘hot gallbladder’ list.

**COMMENT ON**

doi 10.1308/003588408X261627

RPS Gambhir, Armed Forces Medical College, Pune, India

**CORRESPONDENCE TO**

RPS Gambhir, Department of Surgery, Armed Forces Medical College, Pune 411040, India

E: rps_gambhir@rediffmail.com

The authors must be commended on their elaborate effort to prove the futility of D-dimer testing in postoperative patients. Innumerable studies have been done to try and prove the usefulness of D-dimer testing along with pre-test probability score, all aimed at avoiding expensive imaging.1–3 The study could have been more meaningful if they had clarified the following issues:

1. The specificity and sensitivity of D-dimer levels vary with the type of test–enzyme-linked immunofluorescence assay (ELFA), microplate enzyme-linked immunosorbent assay (ELISA) or latex quantitative assay; the authors have not mentioned which test type did they use.4
2. In the historical controls, only 37% patients had deep vein thrombosis (DVT) on or before day 7 after joint replacement surgery. The assessment of D-dimers preoperatively and on postoperative days 1, 3, 5, 7 and duplex imaging on day 7 would have missed out a major proportion of patients likely to develop DVT (up to 65%). Considering the fact that the authors first presented this work in 2005, follow-up data on these 78 patients, if available, could have made the present publication more meaningful.
3. The value of day 1 D-dimer in the published abstracts5–6 of their presentations is 3.63 compared to 3.59 in the present article, without any obvious change in any other numbers, probably a typing error in the present article.

D-Dimer should remain as a screening test for proximal DVT and pulmonary embolism for out-patients with low clinical probability of DVT, where it obviates the need for a duplex ultrasound examination. Positive D-dimer, irrespective of its value, has little meaning when the probability of clinical DVT is high.

**References**


**COMMENT ON**

doi 10.1308/003588408X318138


doi 10.1308/003588409X428432

**Points for clarification**

DAVID BIRCHLEY

Department of Vascular Surgery, Derriford Hospital, Plymouth, UK

**CORRESPONDENCE TO**

David Birchley, Department of Vascular Surgery, Torbay Hospital, Lawes Bridge, Torquay, UK

E: dbirchley@hotmail.com

I read this paper with interest and congratulate the operating surgeon on his low cranial nerve injury rates. I would be grateful for clarification regarding the following issues. Why were there 225 exclusions? Did the cranial nerve injuries occur early in the series or late and were they the reason for the stated change in approach? What is meant by ‘targeted follow-up’ and how long did the injuries take to resolve (i.e. was this a reflection of the effect of local anaesthetic infiltration or tension neuropraxia)? Why was the chi-squared test used for such small numbers of complications?