Urine testing for acute lower abdominal pain in adults

Sir
We read with interest the recent article pointing out the value of urine testing with reagent strips on the ward to rule out urinary tract infection (Br J Surg 1994; 81: 1460–1). We would like to point out that, apart from this valuable test, a dipstick test of urine to assess the presence of bilirubin is also very useful. Any doctor faced with the emergency admission of a patient with upper abdominal pain and tenderness, and with clinical evidence of cholecystitis, would like to know whether there was an element of subclinical jaundice. Liver function testing, although very satisfactory, is usually not available after normal working hours and particularly over weekends. If there has been transient obstruction to the common bile duct abnormal liver function may recover completely in 24 h and may therefore never be documented. This problem could be obviated if a simple test of the urine was carried out soon after admission with reagent strips sensitive to bilirubin.

We carry out this test routinely and find it invaluable for the immediate assessment of patients admitted as an emergency with abdominal symptoms outwith routine laboratory hours. However, recently, newer and less expensive reagent strips without the ability to test for bile have been introduced for routine use on all wards at our hospital, and it is only with some considerable difficulty and perseverance that we have managed to continue the use of bile-sensitive strips on our ward (the only one in this hospital). Although there may be some financial advantage in using strips with fewer reagents, we feel that this is only a short-term benefit and that expenditure will be incurred by keeping patients in hospital longer as they await the results of blood tests.

We therefore recommend the routine dipstick testing of urine for bilirubin in the immediate assessment of patients with abdominal pain as well as the described tests for urine infection, as reported by Mr Ravichandran et al.

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Patterns of reflux in recurrent varicose veins assessed by duplex scanning

Sir
We read with interest the Short Note by Messrs Redwood and Lambert on patterns of reflux in recurrent varicose veins (Br J Surg 1994; 81: 1450–1). They make no mention in their series of neovascularity1−3, a well established cause of recurrent varicose veins. Is this because they cannot see this phenomenon by duplex scanning or because it was not present? An incompetent saphenofemoral junction (SFJ) is quoted to be present, either alone or in combination, in 87 limbs (68.5 per cent). However, under Methods they mention recurrence ‘from the area of the SFJ. Could it be that some of these recurrences actually represent neovascularity?’ Using colour flow duplex (Acuson, Uxbridge, UK) scanning we have found recurrence from the area of the SFJ, alone or in combination, in 72 per cent (84 legs) – similar to the figure quoted by Messrs Redwood and Lambert. Of these, 54 per cent were due to neovascularity and the remaining 18 per cent were persistent SFJs. The presence or absence of the long saphenous vein (LSV) is not mentioned. We found it to be present in 76 per cent of cases and 88 per cent of these were present in the upper thigh, indicating that no attempt was made to strip the LSV. Neovascularity was found in seven legs in the absence of the LSV – these patients had thigh varicose veins.

Another phenomenon we have noted is the presence of long thin tortuous veins arising from the pelvis and contributing to the recurrence in two of 84 legs. Have Messrs Redwood and Lambert seen such veins?

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Subcuticular wound closure: alternative method of securing the suture

Sir
With the advent of monofilament absorbable sutures one has to question why Mr Williams and his colleagues (Br J Surg 1994; 81: 1312) are still using removable sutures for subcuticular wound closure. A study in our unit showed that for this type of closure PDS II (Ethicon, Edinburgh, UK) gave better results than Prolene (Ethicon)1. Experience in our unit of using the method of securing the suture described by Mr Williams and colleagues would suggest that this might cause skin irritation. For many years we have used a subcuticular wound closure. A study in our unit showed that for this type of closure Prolene is superior to polydioxanone (PDS).1


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