and help career growth.

3. A paper does not have to be a rare case or a rare hypothesis. It can very well be a common topic or subject with a message to take home.

4. Published literature gives clinicians a standard with which they can compare themselves.[2]

5. One is more protected medicolegally if one has a practice that is consistent with published scientific material.

Sanjay Dalmia
Department of Surgery, Calcutta Medical Research Institute, Kolkatta, India. E-mail: dalmiasanjay@hotmail.com

REFERENCES


Comment on: Role of water-soluble contrast study in adhesive small bowel obstruction: A randomized controlled study

Sir,

I read this above-mentioned article with interest.[1] I have some serious questions regarding this study and I want to know the opinions of the editor and the experts in the field.

1. Authors say that waiting for 24-48 hours to see the results of Gastograffin reaching the colon is safe and reliable and helps in the management of acute intestinal obstruction due to postoperative adhesions.

All surgical textbooks advise us never to allow the sun to rise or set over an obstructed bowel. That means, if you get a case of intestinal obstruction in the night, laparotomy must be performed before the morning and if the you get the case in the morning, the laparotomy should be finished before the night. The danger is in delay and not in the surgery. Of course, there may be a few cases in which, depending upon clinical signs and symptoms, a few hours of observation may be safe. But this cannot be advised in general for all cases.

2. The authors have not mentioned operative findings in the results’ section, which is a very critical omission. (How many cases required bowel resection in the study and control groups?)

3. The authors have mentioned that five patients required surgery contradicting their own statement in the “materials and methods” section: “…..all patients in whom radiological contrast didn’t reach the caecum within 24 hours was operated”. What made the authors operate on these five patients violating their protocol of the study?

4. In the materials and methods section, they describe their method of selection to be allotting the patients alternatively to study and control groups. If this is done properly, each group should get 16 out of 32 cases and not 17 and 15 as mentioned in the study.

5. ROC curve. The graph plotted with sensitivity vs 1-specificity.

What does it depict/ explain? Explaining the curve, authors say, “…it can be seen from the graph that maximum area of the curve (~85%) lies between 12 and 18 hours. Actually, the graph neither shows 85.5 nor any time interval of 12–18 hours. What are the authors trying to say?

6. Sensitivity 100% and specificity 60%: (Or should it be sensitivity 60% and specificity 60%). Sensitivity 100% means not even a single pathological case should be missed, i.e, there should not be any false negative case. Here two cases required surgery where the test suggested “no surgery”. What is the formula that the authors have used to arrive at the figure of 60% specificity? (Or is it 14/17 x 100 = 82.35?).

7. In the results, the authors have mentioned that five cases were operated within 24 hours. Again they mention “…..14 of 17 cases oral feeding started as contrast reached caecum within 24 hours”. How
is this possible? If five cases are operated within 24 hours, only 12 cases and (not 14) remain for observation till 24 hours. Is it not?

8. There are other concerns, which deserve to be mentioned in the study, but have been missed. What happened to the unoperated cases in the follow-up? Did any of them get readmitted with recurrent obstruction or need surgery in the follow-up?

After reading the paper, I got the impression that the “study” is a reconstructed version of a dissertation of a postgraduate student. IJS should pay attention to the quality of its papers and subject them to review by the experts in the field.

H. K. Ramakrishna
Lakshmi Surgical Clinic, New Bridge Road, Bhadravathi - 577 301, India.
E-mail: swarama@hotmail.com

REFERENCE