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SATURDAY 26 MARCH 1988

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NO 6626 BRITISH MEDICAL JOURNAL 1988 VOLUME 296 875-946 BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR WEEKLY. ISSN 0267-0623
POSTMASTER: SEND ADDRESS CHANGES TO: BRITISH MEDICAL JOURNAL, C/O MERCURY AIRFREIGHT INTERNATIONAL LTD INC, 2323 RANDOLPH AVENUE, AVENEL, NJ 07001, USA
US SUBSCRIPTION $146·00 US SECOND CLASS POSTAGE PAID AT RAHWAY NJ

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The full potential of ultrasound

SIR,—When the problem of funding the National Health Service is debated it is surprising that so little attention has been paid to ultrasound.

The most expensive technological diagnostic advances have been computerised tomographic scanning and magnetic resonance imaging—both important, highly desirable, and impressive, yet neither has made much impact on the standard practices of a general hospital *x* ray department.

Ultrasound, on the other hand, is a small, mobile, inexpensive, and unimpressive machine, now seen in most (perhaps all) hospitals, not only in *x* ray departments but also in obstetric, paediatric, cardiac, and doubtless other clinics or wards and operated not only by radiologists. At perhaps one tenth of the price of a computed tomography scanner, at a mere fraction of the service and running costs, and plugged into a standard 13 amp socket, it offers no competition whatsoever in terms of status. Yet, for many reasons, it has more to offer, and should by now have revolutionised investigatory practices.

Clinical ultrasound requires no unpleasant preparations or injections and is safe. The cost of an investigation is the time of the operator and the price of one, two, or occasionally three 40p films. It is absolutely operator dependent, and for this reason should be, except for echocardiography, entirely the preserve of the *x* ray department, where radiologists can acquire the necessary skill to offer a definitive diagnosis, usually based on a single investigation. Credence given to wrong diagnoses made by inexperienced or inexpert operators will inevitably result in the facility falling into disrepute.

Unlike computed tomography and magnetic resonance imaging, an ultrasound examination is done in real time and since the probes are hand held a lesion or a search for a lesion can be viewed from an infinite number of angles and positions. Consequently, what amounts to a rapid bloodless laparotomy or laparoscopy can be done accurately by operators who have a knowledge of anatomy, pathology, surgery, medicine, and gynaecology.

If the full potential of ultrasound is to be exploited it is necessary to break with certain aspects of traditional radiography and provide a service for all disciplines, including general practitioners, which offers, wherever possible, a definitive diagnosis based on a single investigation, as in a laparotomy or other surgical exploration, with no recourse to computed tomography or other investigations. Such indications would include diseases of the liver, biliary tree, pancreas, spleen, genitourinary system, and pelvic viscera; intra-abdominal tumours; abscesses; trauma; pyloric stenosis; intussusception; and congenital dislocation of the hip. Ultrasound should also be used as a rapid preliminary screen for patients undergoing barium enema and barium meal and follow through examinations and intravenous urography since, despite bowel gas being a hindrance, it is often possible to identify tumours of the bowel or Crohn's disease or some other expected or unexpected lesion and thus either avoid doing an unnecessary investigation or modify it in some way.

What I propose has been achieved at this hospital, where we enjoy the full confidence of the clinical staff, who will treat or operate on the basis of a single examination diagnosis. There can be little doubt that the savings in terms of radiographic equipment and materials, bed occupancy, theatre time, nursing, and so on, are considerable. Translated nationwide . . .?

With such obvious advantages, one would have expected the profession to have embraced ultrasound and implanted it in the very front line of medical practice—but not so. The lobby in both the National Health Service and the private sector is so powerful that there is every indication that computed tomography requests will soon make it almost a routine investigation, while ultrasound will be relegated to the second and third division—and that will be a great opportunity missed.

S MINDEL

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Late life depression: undertreated?

SIR,—Dr Bob Baldwin's admirable leading article (20 February, p 519) hits a welcome note of optimism about both response to physical treatment and prognosis in late life depression. It remains clear, however, that many elderly depressed patients fail to respond to initial attempts at treatment.[1]

Pharmacological strategies for resistant depression[2] may be poorly tolerated in the elderly. Several open and controlled clinical trials in depressed non-elderly adults suggest that the addition of lithium in cases where the response to tricyclic antidepressants is poor is successful in 50-60% of cases.[3] To our knowledge, however, only one paper has specifically examined lithium augmentation in elderly depressed patients: good responses were achieved in five, but the overall success rate was not recorded.[4]

We treated nine patients with lithium augmentation who had failed to respond to tricyclic