Diagnosing Abdominal Aortic Aneurysm

To the Editor: The article by Drs Lederle and Simel1 brings to the clinician’s attention the serious nature of abdominal aortic aneurysms (AAAs). While the article will serve as a valuable reference for clinicians, their last sentence must be disputed. When a ruptured AAA is suspected, imaging studies such as ultrasonography or computed tomography should not be performed. When a patient presents to the emergency department or a physician’s office with hypotension, a pulsatile abdominal mass, and associated flank or abdominal pain, the patient should be taken directly to the operating room for exploration and repair of a ruptured AAA. Delaying operation with imaging studies only allows the patient's condition to become more unstable. Patients may die as a result of delay while awaiting preoperative studies. It has always been my contention that more patients will die of an AAA on the table of a computed tomography scanner than will die on the operating table. It is better to treat a nonruptured aneurysm as an emergency than to treat a ruptured aneurysm electively.

James T. Callis, MD
Jefferson Surgical Clinic
Roanoke, Va

1. Lederle FA, Simel DL. Does this patient have abdominal aortic aneurysm? JAMA. 1999;281:77-82.

To the Editor: Drs Lederle and Simel1 state “the only physical examination maneuver of demonstrated value for the diagnosis of an AAA is abdominal palpation.” This is not quite accurate. I have found that visual observation of the relaxed abdominal wall in medium and large AAAs often gives the examiner a sense of a pulsatile mass in the mid abdomen, especially if the clinician observes the abdominal wall somewhat tangentially from the patient’s side, rather than from directly over the patient’s abdomen. When this finding is demonstrated to medical students and residents, it is quite instructive for them to actually visualize the location of the pulsatile mass in the central abdomen.

Second, it may be too basic to mention, but it is common to witness students, residents, and practicing physicians palpating for a pulsatile mass without holding their hands still. The pulsatile nature of an intra-abdominal structure cannot be appreciated when the examiner’s hands are in motion.

George B. Friend, MD
General and Vascular Surgery, PC
South Bend, Ind

In Reply: We agree with Dr Callis that patients with abdominal pain and shock should be taken directly to the operating room. However, many patients with ruptured AAAs have a more subtle presentation, and, in these cases, diagnostic confirmation is often necessary.1 Our intention was to emphasize that once a ruptured AAA is suspected, physical examination alone should not be relied on to exclude the diagnosis.

Dr Friend has proposed a physical finding that, to our knowledge, has not been previously reported in the literature. Until data are presented demonstrating its value, we stand by our statement. We have recently evaluated a similar finding, the transmitted epigastric pulse, and found it to be without value (unpublished data, 1999). We agree that the examiner’s hands should not be moving as the aorta is assessed between the 2 index fingers and hope that this was implied in our description, but we thank Friend for emphasizing this point.

Frank A. Lederle, MD
VA Medical Center
Minneapolis, Minn


CORRECTIONS

Incorrect Data: In the Original Contribution entitled “The Cost-effectiveness of Preventing AIDS-Related Opportunistic Infections” published in the January 14, 1998, issue of THE JOURNAL (1998;279:130-136), the cost-effectiveness ratios in dollars for Pneumocystis carinii pneumonia and toxoplasmosis prophylaxis were incorrect. In Table 3 on page 133, the ratio should be 2300 (not 16 000) per quality-adjusted life-year saved. In Table 4 on page 134, in the analyses unadjusted for quality of life and assuming combination antiretroviral therapy, the ratios should be 1900 (not 13 000) per year of life saved; and 10 200 (not 22 000) per quality-adjusted life-year saved, respectively. In Table 6 on page 134, the ratio for strategy 2 should be 2300 (not 16 000) per quality-adjusted life-year saved. The revised data do not affect the article’s policy conclusions.

Incorrect Number: In the Original Contribution entitled “Starting Insulin Therapy in Patients With Type 2 Diabetes: Effectiveness, Complications, and Resource Utilization” published in the November 26, 1997, issue of THE JOURNAL (1997;278:1663-1669), there was an incorrect number in the “Results” section. On page 1666, in line 20 of the first full paragraph, the percentage should be 15%.