

## Teaching Surgical Skills

**TO THE EDITOR:** Reznick and MacRae (Dec. 21 issue)<sup>1</sup> report on the current status of simulation in surgical-skills training and its various applications. Another potential use of simulation is as a part of the curriculum for medical students, with an aim to introduce hands-on skills training and evaluation early in their career. During surgical clerkships, only 67% of surveyed students thought that the surgical teaching and exposure they had received was adequate,<sup>2</sup> and the majority of the exposure involved minor, “less risky” parts of surgical procedures, such as tying knots or cutting sutures. Perhaps the exposure of students to surgical simulation would allow them to appreciate their own technical ability, would reveal whether they were interested in participating in technical procedures, and would therefore influence their choice of residency training.

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1. Reznick RK, MacRae H. Teaching surgical skills — changes in the wind. *N Engl J Med* 2006;355:2664-9.

2. Ek EW, Ek ET, Mackay SD. Undergraduate experience of surgical teaching and its influence on career choice. *ANZ J Surg* 2005;75:713-8.

**THE AUTHORS REPLY:** Drs. Dandolu and Newmark outline another potential application of training using surgical simulation. Although our article concentrated primarily on postgraduate training, we wholeheartedly agree that undergraduate students also benefit from training in a surgical-skills laboratory setting. In our institution, a trial program of skills training was implemented at one of the four major teaching academies. Other students demanded to be included, and we now offer laboratory-based skills training to every medical student at the beginning of the surgical clerkship. This type of training benefits not only future surgical residents but also all future physicians who require technical skills in their practice.

We would like to address one other issue relating to our article. Since its publication, we have heard from several colleagues who have correctly pointed out that William Stewart Halsted, the great American surgeon, was never knighted.

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## A Medical Mystery: Dilated Bowel — The Answer

The medical mystery in the February 1 issue<sup>1</sup> involved a 70-year-old man who presented with a history of increasing abdominal distention. The patient was evaluated by means of computed tomography (CT) after an abdominal radiograph raised concern about a sigmoid volvulus. The diagnosis of a colonic pseudo-obstruction was made after the CT scan and a follow-up contrast enema study showed dilated loops of colon extending to the rectum, without evidence of blockage or perforation. An underlying parasitic infection was ruled out by means of additional laboratory testing.

The CT scout image, however, provided a clue to the patient's disease. With the patient lying still on a CT-scanner table, the scout image was acquired on a 64-detector-row CT scanner. The scout image was used to preview the area of interest for subsequent CT imaging. It revealed an unusual sinusoidal artifact involving the pa-

tient's right forearm (Fig. 1A). The patient's concurrent electrocardiogram (Fig. 1B) showed an analogous artifact, mimicking an atrioventricular block. This rhythm is in fact a normal sinus rhythm with superimposed, sharp pseudo-flutter waves (Fig. 1B) that are not associated with the QRS complex.

This case shows several features of a Parkinsonian tremor, while highlighting the association between Parkinson's disease and a colonic pseudo-obstruction. The tremor is present at rest and is often confined to one limb. Besides the classic “pill-rolling” tremor, pronation-supination of the hand and forearm, as seen in this patient, is a common presentation. The frequency of the tremor is typically between 3 and 5 cycles per second. In this case, on the basis of a CT scout table velocity of 79 mm per second and an electrocardiographic sweep speed of 25 mm per second, the tremor frequency was esti-