

ficity to rule out or rule in pelvic disease. But emergency medicine is not so simple, and we use many tests that are not definitive. If only it were true that we could ignore clinical findings and just order a test to make every diagnosis — perhaps run all patients through a universal scanner! In reality, we must weigh information from the history and physical examination, formulate a differential diagnosis and use clinical features to guide further investigations. For the pelvic exam to be discarded, it would have to be more misleading than helpful, and even the studies cited do not suggest this.

Let's look at the studies presented as evidence.

The study by Close and coworkers,² which was used as evidence that bimanual exam is unreliable, was designed to fail. If one physician was unsure about a finding and the second physician thought the finding was absent, the authors considered this a discrepancy (error). Yet the data still showed 82% agreement on cervical motion tenderness, 72% agreement on adenexal and uterine tenderness and 84% on the presence of adenexal mass. The study by Padilla and cohorts³ concluded that the pelvic exam is 79%–92% specific and only 15%–36% sensitive for adenexal masses. But this study³ looked at anesthetized patients, a very different group than the awake patients emergency physicians examine — patients who are capable of indicating the location of tenderness, therefore helping to guide us to the location of the mass. Two studies,^{4,5} published before the availability of sensitive beta-hCG tests, were cited to show the unreliability of pelvic exam in pelvic inflammatory disease (PID). Given that the authors at this time were not even able to reliably detect pregnancy, it is not surprising they had difficulty making a correct diagnosis using physical exam alone. Today, the

first decision point — pregnant/not pregnant — is easy; then we use the pelvic exam to guide ancillary investigations such as cervical cultures, ultrasound, and even CT. A study by Houry and Abbott⁶ was cited as evidence that pelvic exam is unreliable in detecting ovarian torsion, but this was a retrospective chart review where, if the physician failed to adequately document pelvic exam findings, the findings were considered to be absent. It is inappropriate to make conclusions about the value of the physical exam using this retrospective methodology.

Of note, a well-designed study by Dart and colleagues⁷ identified several pelvic exam findings, including cervical motion tenderness, lateral pelvic tenderness and uterine size less than 8 weeks, that are thought to be useful in diagnosing ectopic pregnancy. Although these authors did not identify a combination of findings highly accurate for ectopic pregnancy, they concluded that history and physical examination will continue to play an important role in determining the need for emergent ultrasound.

Two papers^{8,9} were cited to show that ultrasound is superior to clinical examination. But both reported remarkable specificity (and reasonable sensitivity) for bimanual examination, and neither groups suggested that the pelvic exam was useless. In fact, Andolf and Joergensen⁸ concluded that ultrasound was a useful complement to pelvic exam, but that neither modality reliably detected tubal anomalies, while Frederick and cohorts⁹ concluded that vaginal ultrasound is an effective routine adjunct to physical examination in the preoperative evaluation of surgical patients.

Brown and Herbert conclude that clinical examination of the female pelvis is not an adequate, reliable or reproducible method for evaluating sig-

nificant pelvic pathology, but does their article make a compelling and evidence-based case supporting this conclusion? I for one would want better evidence before abandoning pelvic examinations.

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Pneumatosis intestinalis

To the Editor: I would like to commend Dr. Liu and colleagues on their excellent case report,¹ “Benign pneumatosis intestinalis: a cause of massive pneumoperitoneum in the adult.” The *Canadian Journal of Emergency Medicine* arrived at my house on Wednesday, and by Friday I was able to put the arti-

cle and its excellent photoradiographs to good use. In doing so I noted that this syndrome is not discussed in *Rosen's Emergency Medicine* textbook.

My interest in your case report arose when a 90-year-old woman was transferred from another institution to us via our imaging department. She had suffered the onset of abdominal pain and bloating that morning, and the CT revealed massive pneumoperitoneum. The attending surgeon requested that preparations be made for immediate laparotomy pending his arrival. As emergency physicians gener-

ally attempt to do with all patients passing through their department, I quickly reviewed the patient, noting how benign her belly felt, and noting the presence of normal laboratory values. At this point I reviewed the CT report, which read: "massive pneumoperitoneum suggestive of air-filled cystic structures."

Following discussion with the attending surgeon and CT radiologist, it was agreed that the patient did not warrant immediate laparotomy. By the following day the patient was able to start eating again. No ischemia, inflammation

nor increased intraluminal pressure effect was identified.

I thank you for this excellent Case Report.

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Reference

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Les lettres seront considérées pour publication si elles sont pertinentes à la médecine d'urgence en milieu urbain, rural, communautaire ou universitaire. Les lettres en réponse à des articles du *JCMU* publiés antérieurement devraient parvenir au siège social du *JCMU* à Vancouver (voir titre pour plus de détails) moins de six semaines après la parution de l'article en question. Les lettres ne devraient pas avoir plus de 400 mots et cinq références. Pour des raisons d'espace et par souci de concision et de clarté, certaines lettres pourraient être modifiées.