

# The vascular surgery training programme: room for improvement?

**Sir,**

The new vascular surgery programme is in its infancy. One effect of the new programme may be to remove ST4 trainees from the general surgical on call commitment in order to make them available for exposure to more elective open and endovascular cases at an earlier stage in their training. Furthermore, core trainees coming through to become ST3s are lacking the surgical exposure and experience of previous trainees, which would suggest that they require additional years of surgical exposure at registrar level.

Senior vascular trainees report limited operative experience and confidence in performing complex open and endovascular procedures (Richards et al, 2008; Duran et al, 2013). Integrating training between vascular surgery and interventional radiology would significantly increase the case mix and operative exposure for vascular trainees, but this would need a vascular rota filled with pure vascular trainees across the nation.

However, not all regions in the UK can manage a middle grade vascular on-call rota, which means that general surgical middle grade trainees are managing the bulk of vascular emergencies out of hour. This reduces the exposure of vascular trainees as the first point of call for emergencies.

The new general surgical curriculum has made vascular surgery an optional rather than mandatory placement for trainees. Is this sufficient training for future general surgeons? The authors believe not, especially as the need for vascular surgery will continue to increase in future with the increase in the number and complexity of vascular conditions which are more prevalent in the aging population, and those linked to smoking and diabetes. This further supports the authors' argument that vascular trainees should be trained in their speciality as soon as possible.

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## An alternative method of central line insertion using a 16 G cannula

**Sir,**

This interesting article (vol 78(2), 2017, p. 112; <https://doi.org/10.12968/hmed.2017.78.2.112a>) suggests an alternative method for dilating a puncture tract to allow a central venous line to be passed in case the original dilator is unusable. I was pleased to read that using an intravenous cannula was successful in this particular instance but find it a little difficult to believe that this should be considered a 'convenient emergency alternative' over and above locating a fresh dilator.

My concerns are as follows: first the soft plastic used for a cannula is qualitatively

quite different from the stiff material that comprises a central line dilator and would certainly be too soft to dilate the subcutaneous tissues in many cases. Second the sharp steel trocar inside a cannula introduces a new complication risk that is not present with the blunt plastic dilator.

As a relatively minor correction the central venous catheter dilator is opaque, contrary to the description in Aladin and colleagues' report. Furthermore an orange cannula is 14G, not 16G, as described throughout the article. Although it would be interesting to learn if a central line guidewire could indeed pass down the lumen of a 16G

cannula, I am still not sure that it would be a good idea to consider an intravenous cannula as an effective alternative to the central line dilator.

I understand that the authors are suggesting that this should only be considered in an emergency but I am yet to encounter a scenario in which locating another dilator was not possible.

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