

detected after discharge, suggesting that the proportion of patients reached by out-of-hospital surveillance in that study, and in NNIS hospitals as a whole, is even less than that in our study. What renders our practice incomparable to that of most hospitals in the United States is, first of all, irreconcilable differences in surveillance methods.

For these reasons, we agree with Chen et al.¹ that our results must not be generalized to patients in the United States, and to the same extent, the results of US studies must not be generalized to our patients. It is not clear why they suggest that a study could be generalized to a population other than that from which the sample was retrieved.

Chen et al.¹ should explain further why it may not be possible to use data on the risk of SSI collected prior to 2000 in a cohort study with concurrent controls. This concern may be more relevant for a study using historical controls. Increases in conversion rates are mainly driven by changes in the spectrum of indications for laparoscopic cholecystectomy.¹² The inclusion of the year of surgery as explanatory variable was the only possible means to address this in our data.

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Are We “Squeezing The Balloon” When Reducing the Risk of Occupational Infection? Reply to Pan et al.

TO THE EDITOR—Under a witty title, Pan et al.¹ described a needlestick injury that occurred while a cytopathologist was performing fine-needle aspiration cytology (FNAC) using the modified method that I and my colleagues proposed² to eliminate the needle manipulation involved in classical FNAC. They relate that the needle shot out when the cytopathologist depressed the plunger to extract the material obtained by aspiration, and they suggest a possible cause: the needle was clogged by a colloidal clot aspirated from a thyroid nodule. Unfortunately, the needle bounced and lodged in the cytopathologist’s scalp. With no other argumentation, they assume that clot aspiration is inherent to the modified method of FNAC and so is a new injury risk associated with use of the modified method.

I agree that a clot might have clogged the needle and caused the accident. Nevertheless, I don’t know the physical law that explains why aspiration of a clot is only possible when using the modified FNAC technique and not when using the conventional FNAC method. Also, the reason for which the needle’s odd flight path and its unlucky ending must be considered an exclusive result of the modified FNAC method eludes me. My personal experience includes more than 6,500 FNAC procedures, more than 3,500 of which were performed with the modified method. Although I cannot determine the exact number, I have had a few experiences with both classical and modified FNAC in which the needle shot out suddenly when I depressed the plunger. Fortunately, no injury ever followed.

Finally, I don’t see the line of argument by which Pan et

al.¹ conclude that reporting a diagnostic method that, with no loss of effectiveness, permits us to eliminate needle manipulation and hence, to reduce the risk of injury, is equivalent to “squeezing the balloon.” Again, I am in perfect agreement with Pan et al.¹ when they recommend that we use our heads to perform FNAC safely. However, and to avoid misunderstandings, I would dare to specify their advice further, adding that, if possible, we shouldn’t use our scalps, but we should make use of our common sense.

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