the radiologist's interpretation of the CT study is the correct one. At best, this is a modal fallacy, confusing possibility with necessity. At worst, it is an argument of false authority and begs the question in that the authors' unique perspective on the diagnosis of inguinal hernia is used as a premise.

Finally, the authors provide correlation of their operative findings with their radiologist's imaging interpretations as results, but they provide no data on patient outcomes. One does not know whether the patient's symptoms were relieved and, if so, for how long. In a similar paper published by these same authors,[2] the writers blithely cite PJ Yong and colleagues,[3] stating, that "Although a hernia repair resolves the patient's presenting symptoms…" In point of fact, Yong and associates[3] conclude, "In select women with chronic pelvic pain, empiric laparoscopic inguinal exploration and mesh placement results in moderate improvement in outcome." Specifically, Yong and colleagues[3] note that there was pain improvement in 15 patients (35%); pain improvement, then return of the pain in 18 patients (42%); pain unchanged in 9 patients (21%), and worse pain in 1 patient (2%). Even if the patients experienced relief, it could not be surmised as to whether the same relief would be provided by a sham surgery as opposed to a repair of an anatomic inguinal hernia per se. In short, the cited outcomes do not support the rationale for surgery.

It is well known that surgical repair of palpable inguinal hernia with the intent of relieving chronic groin pain is often incompletely successful and may even lead to a worsening of symptoms. If one narrows the field to patients with small or occult inguinal hernias, then the utility of surgery is even less.[4] In this context, an argument in favor of expanding the pool of patients undergoing surgical repair of hernia to include so-called occult inguinal hernia seems misguided.

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Occult Inguinal Hernias Matter

In reply to Kaplan and colleagues

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We thank the authors for their letter, as radiologic interpretation of inguinal hernias is a topic of interest to surgeons, and this gives us an opportunity to address the important, yet debated, topic of occult inguinal hernias.

Let us clarify that symptomatic inguinal hernias are indeed a subset of inguinodynia diagnosis.[1] No evidence supports the "belief that hernia and inguinodynia are distinct diseases." In fact, an impetus for our manuscript was to help correct such beliefs shared by surgeons and radiologists.

It appears the authors have misread the purpose of our manuscript.[2] It was not to report our surgical outcomes. We previously showed that inguinal hernia repair for inguinodynia or chronic pelvic pain can be curative for 78% to 89% of patients on long-term follow-up.[3,4] We disagree that "the same relief would be provided by a sham surgery" because the patients we treat for occult inguinal hernias have suffered from their symptoms for 96 weeks, on average.

History is the most important factor to determine if occult inguinal hernia should be in the differential diagnosis of inguinodynia.[3] Physical examination is also important: point tenderness over the internal ring is a highly sensitive finding (96% to 100%) for occult inguinal hernia.[3,4] Not being able to see or palpate a bulging mass on examination does not rule out an occult inguinal hernia as the cause of groin pain. Radiologic studies are intended only as an adjunct to confirm the presence of inguinal hernias if there remains diagnostic uncertainty.[5] A failure in this sequence of events is what has brought many patients to our practice—cross-sectional imaging studies in hand.

In our retrospective study, the decision to operate on a patient with groin pain was not based on preoperative consultation with a radiologist, but rather, on our surgeon's own evaluation of history, physical examination, and available imaging. The impetus for this manuscript was the experience that the radiologic reports accompanying the imaging studies were often inaccurate and disparate from our surgeon's interpretation. If our surgeon were to rely solely on radiologic interpretation of imaging, then a large proportion of her patients would have been denied curative hernia surgery for their groin pain (note that even our expert radiologist was unable

to accurately interpret imaging for hernias in all the imaging, with 79% overall accuracy).

The conclusion of our manuscript is that physicians should be critical of the radiologic reports issued for inguinodynia or chronic pelvic pain, given the high false negative rate of pelvic CT (73%) and MR imaging (43%) reports in detecting inguinal hernias. Accurate interpretation of imaging in these patients may help reduce delay in diagnosis and help expand the population of patients who would benefit from surgical repair.

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Acute Care Emergency General Surgery Model: Assigning Priority

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I read with great interest the article entitled, "Acute care surgery model and outcomes in emergency general surgery" in the *Journal of the American College of Surgeons*, by To and colleagues.[1] This is the first multi-institutional study that showed significant reduction (31%) of 30-day mortality in emergency general surgery (EGS) cases in an acute care surgery (ACS) model compared with that of the general surgery service (GSS) model. It delivered an important message worldwide, where EGS is being delivered in the GSS model by surgeons with subspecialty interests or with suboptimal training in EGS.

Patients requiring EGS are unwell, often old and frail, with major other health problems that significantly increase the risk of postoperative complications and death. Providing unrestricted access and high-quality EGS service remains a global challenge, particularly in low- and middle-income countries (LMIC) of the world. In a prospective, multicenter cohort study, which collected data on 10,745 patients from 357 centers in 58 countries, who underwent emergency abdominal surgery, the 24-hour (high 1.1%, middle 1.9%, low 3.4%; $p < 0.001$) and 30-day (high 4.5%, middle 6.0%, low 8.6%; $p < 0.001$) mortality were 3 times higher in LMIC compared with mortality in high-income countries.[2]

In England, more than half of approximately 600,000 EGS patients admitted present with acute abdomen. In 2014, The Royal College of Surgeons of England, in association with other royal medical colleges, published a report giving 13 recommendations to make the emergency service sustainable and resilient.[3] Similar recommendations were also made by the National Institute for Health Research and National Clinical Advisory Team for reconfiguration of the acute surgical services in the UK, which focused on safety, work force, and cost as the 3 key drivers for the success of EGS provision. Delivery of 24-hour service led by a senior decision-maker (consultant) and supported by relevant specialists and facilities was emphasized, and this has been implemented and evaluated continuously. To improve the EGS service in the UK, initiatives such National Emergency Laparotomy Audit (NELA) and Enhanced Peri-Operative Care for High-risk Patients (EPOCH) trial are underway.[3,4]

There are handful of substantive consultant posts in EGS in the UK National Health Service. It is believed that patients and funders could benefit from a new specialty of EGS, in which unscheduled emergency admissions are managed by a dedicated consultant-led team. The options of models include consultant of the week, consultant with interest in EGS, and consultant in EGS.[5]

It is commendable that the US currently has 20 approved acute care surgery training fellowship programs and has demonstrated leadership in advancing EGS through the ACS model. This study, despite several limitations, has delivered an important message to the surgical fraternity to move forward and assign priority to embrace the ACS model in the best interest of EGS patients. Motivating surgeons, who are the pillars of the ACS model, to pursue career in EGS remains a major challenge worldwide, and it should be addressed by developing appropriate infrastructure, training schemes, and an environment that would allow optimum work-life balance, and quality assurance.[6]