

Sonoscopy in Clinical Practice

Deepak Raj Singh

Shakespeare in his play Romeo and Juliet wrote that a rose by any other name would smell just as sweet. I am often asked by juniors, seniors, colleagues and students alike as to the difference between ultrasound and sonoscopy. The simple answer is that **whereas ultrasound is investigation, sonoscopy is examination.**

Imaging is superior to imagining. As clinicians, all of us have many a time wished that some genie would come to our rescue when the protean presentations of our patients eluded our ability to come to a diagnosis on the basis of relying on our primary senses alone. Sonoscopy is that genie. Advances in technology and miniaturization of the ultrasound machine have made bedside sonoscopy immensely feasible. Stethoscope has long been a symbol of medical fraternity but it is foreseen that sonoscopy will replace the stethoscope from the white coat pockets of all clinicians and medical students alike to take its due position as symbol of medical fraternity.

Even recent edition of Harrison's noted that the lung is not amenable to ultrasound since it contains mostly air, but the work of Prof. Daniel Lichtenstein has shattered that myth as evidenced by the adoption of the BLUE (Bedside Lung Ultrasound in Emergency) by major critical care societies and pulmonary medicine specialists.¹ All regions as well as all the systems of the human body can be inspected with the sonoscope.

Sonoscopy is not only helpful for diagnosis but also in monitoring the progress of the disease as well as in percutaneous intervention. Sonoscopic guided pigtail drainage of pleural effusion, livers abscesses and pelvic abscesses have brought a sea of changes in our own practice. Moreover sonoscopic inspection is much cheaper than CT scan without any adverse effects and can be repeated as circumstances demand.

In our own context, it is heartening to note that obstetric sonoscopy training to health workers in remote districts of Nepal is saving maternity lives in the country. Few international organizations and even companies like Sonosite is helping in this endeavor and untiring efforts of Dr. Mingmar Sherpa and others to bring about obstetric ultrasound facilities to pregnant women of remote areas is highly commendable.

In conclusion many professional societies of the world are embracing sonoscopy in their practice and developing protocols to meet their needs. **POCUS** (Point of Care Ultrasound) is being encouraged by the American college of family practitioners and other general practice societies.² **BLUE** (Bedside Lung Ultrasound in Emergency),¹ **FATE** (Focussed Assessment of Transthoracic Echo)³ or **FOCUS** (FOcussed Cardiac Ultrasound),⁴ **RUSH** (Rapid Ultrasound in Shock and Hypotension)⁵ is being practiced in most critical care units. **FAST** has graduated from (Focussed Abdominal Sonography in Trauma) to **FAST-ABCDE** (Focussed Assessment with Sonography in Trauma) in line with ATLS (advanced trauma Life Support) protocol as developed by the American College of Surgeons.⁶

ASIAA (Abdominal Sonoscopy in Acute Abdomen) is a protocol we have developed at Kathmandu Medical College to assuage the palpitations that residents face when confronting the Pandora's Box in the middle of the night.⁷

Sonoscopy is here to stay for the benefit of our patients. The sooner we incorporate it in our own practice the better for our patients. I would therefore beseech the Society of Surgeons of Nepal (SSN) to take the lead to advocate clinical sonoscopy in the training of our upcoming surgeons.

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Author affiliations:

Department of Surgery, KIST Medical College Teaching Hospital, Lalitpur, Nepal.

Correspondence:

Dr. Deepak Raj Singh, Associate Professor, Department of Surgery, KIST Medical College Teaching Hospital, Lalitpur, Nepal.

Email: drsinghnp@gmail.com

ORCID: <https://orcid.org/0000-0001-8174-9619>

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