



Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the Notice printed on the inside back cover. Tables and figures should only be included if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and to subedit contributions to ensure clarity.

Responses to paper by B Horner

Breast augmentation should be on the NHS: a discussion of the ethics of rationing

Ann R Coll Surg Engl 2002; **84**: 82–3

LETTER 1

BJ Davis, M Jindal, W Kisku

Department of Plastic Surgery, City General Hospital, Stoke-on-Trent, Staffordshire, UK

We read this article with interest and applaud the attempt to argue a difficult case; however, we have some concerns about the use of breast augmentation in the argument. First, the discussion centres around the term 'serious dysfunction'. As rightly stated, GMC guidelines propose that treatment priorities should be on the basis of clinical need; therefore, a term such as 'serious dysfunction' has little meaning without clinical context. Second, it is stated that it is considered inappropriate to offer surgery to women suffering distress due to the social stigma attached to small breasts. This is not true. These women are offered surgery on the NHS after thorough evaluation by the surgeon, together with a psychiatrist for the protection of all parties involved. Psychiatric evaluation forms an important part of the decision-making process as it enables the GMC guidelines on clinical need to be adhered to. Third, some of the women who attend requesting breast augmentation do not have 'small' breasts, and therefore the question of social stigma is not raised. It is the patient's perception of body image that requires treatment. Finally, in the conclusion it is stated that: 'I have shown that when considering the priority a treatment should receive, we often begin with assumptions and performed value judgements'. To state that you have 'shown' implies evidence- or research-based practice. In fact, what you have done is to assume that 'we begin with assumptions' and we would suggest that you are, therefore, a victim of your own argument.

Correspondence to: Mr BJ Davis, Department of Plastic Surgery, City General Hospital, Prince Road Stoke-on-Trent, Staffordshire ST4 4LN. Tel: 01782 715444

LETTER 2

James Henderson

Edinburgh, UK

I have a few concerns about this article. With his 'thought experiment', the author is at risk of suggesting that society places the same value on large breasts as intelligence. Had he referred the patient with the painful number to a surgeon and the one with depression to a psychiatrist, then the thought experiment might be more in line with current NHS practise. It seems reasonable to treat physical pain with surgery (physical treatment), and psychiatric conditions in a psychiatric manner, at least in the first instance. If psychiatric treatment fails to solve depression, then surgery can always be considered subsequently, after appropriate psychiatric assessment (and potential treatment). There are many other 'defects' which might cause psychological distress, that would be amenable to surgery; for example, small or large ears, chin or nose as considered by Klassen *et al.*¹ I agree with the fundamental principle that augmentation surgery should be available for those suffering 'significant distress' from having small breasts, or any other (self-perceived) cosmetic defect, but I am concerned about the way in which this might be assessed. Varicose vein surgery was a topic of similar debate, and this is a condition that in addition to causing a cosmetic defect, may lead on to more serious complications (varicose eczema and ulcers). Cosmetic varicose vein surgery (which might also be regarded as prophylactic for ulcers) is not uniformly available on the NHS. If breast augmentation were readily available, then it might be that the NHS was abused by women seeking surgery, in the knowledge that by claiming to be 'significantly' distressed, they would receive an operation. Psychological distress is difficult to assess, (especially if the decision on whether to offer augmentation is made by a surgeon rather than a psychiatrist). The benefits (or

otherwise) of breast enlargement would not become apparent until after surgery. The NHS has to perform rationing on a daily basis. In an ideal world, we could offer cosmetic surgery to any patient whom we felt might gain benefit from it. In the real world, however, patients with more easily verifiable causes for distress, or the potential for complications of untreated conditions, should take priority of resources.

Reference

1. Klassen A, Jenkinson C, Fitzpatrick R, Goodacre T. Patients' health related quality of life before and after aesthetic surgery. *Br J Plast Surg* 1996; **49**: 433–8.

Correspondence to: James Henderson, 26 Mertoun Place, Polwarth, Edinburgh EH11 1JY, UK.
E-mail: jameshenderson999@hotmail.com

*Responses to paper by RS Dua,
MJK Bankes, GSE Dowd, AAM Lewis*

Compartment syndrome following pelvic surgery in the lithotomy position

Ann R Coll Surg Engl 2002; **84**: 170–1

LETTER 1

NRF Lagattolla, J Bond

Dorset County Hospital, Dorchester, UK

We agree with the authors that compartment syndrome is a rare, but extremely important, complication of prolonged surgery in a patient positioned on the operating table with flexed hips. This is felt to be due, at least in part, to arterial insufficiency derived from kinking of the femoral vessels.¹ We would briefly like to highlight our recent experience of compartment syndrome occurring following lengthy surgery, both patients having had urological, rather than gastrointestinal, operations. We believe this association is important because prolonged pelvic urological procedures, such as radical prostatectomy and cystectomy, have become routine. Both cases were men in their late 60s undergoing cystoprostatectomies with formation of ileal-conduits. The first was in the lithotomy position and the second in Lloyd Davis with the operations lasting 3 and 6 h, respectively. In the first case, prompt fasciotomies were performed the day after surgery and an excellent outcome was obtained. The second case was unfortunately investigated for vascular insufficiency by both venography and arteriography, which led to a delay before fasciotomies were performed. The patient's recovery was not very good, developing extensive necrosis in the left anterior compartment. He required debridement and the wound eventually healed. The patient

was discharged mobilising reasonably well on crutches. Whilst our cases have not been extraordinary, we felt it very important to highlight that compartment syndrome is a complication that can occur in fields of expertise other than gastrointestinal surgery. Additionally, our experience emphasises the importance of early identification and prompt treatment to obtain a satisfactory outcome from this serious complication.

Reference

1. Peters P, Baker SR, Leopold PW, Bernard KG. Compartment syndrome following prolonged pelvic surgery. *Br J Surg* 1994; **81**: 1128–31.

Correspondence to: Mr Lagattolla, Dorset County Hospital, Williams Avenue, Dorchester, Dorset DT1 2JY. Fax 01305 254155

LETTER 2

W H Thomson

Gloucestershire Hospitals NHS Trust, Gloucester, UK

I support the authors' message. A young, very fit, muscular male patient of ours developed bilateral anterior tibial and peroneal compartment syndrome after long Lloyd Davies and Trendelenburg tilt positioning.¹ Since then, we have only raised the legs for the final part of a pouch procedure – its anastomosis to the anal canal. We have not seen this complication, which in this case we were lamentably slow to diagnose, since.

Reference

1. Stoodley NG, Thomson WHF. Compartment syndrome: a cautionary tale. *Br J Surg* 1989; **76**: 1297.

Correspondence to: Mr WH Thomson, Consultant Surgeon, Ward 10, 5th Floor, Gloucestershire Hospitals NHS Trust, Great Western Road, Gloucester GL1 3NN, UK.
E-mail: kay.harding@gloucr-tr.swest.nhs.uk

*Response to paper by
JD Beard, J Robinson, J Smout*

Problem-based learning for surgical trainees

Ann R Coll Surg Engl 2002; **84**: 227–9

Gurpreet Singh Ranger

St George's Hospital and Medical School, London, UK

Beard and colleagues discuss the merits of problem-based learning (PBL), and conclude that postgraduate surgical education programmes could 'usefully include PBL'. As a

PBL tutor, I can foresee several problems with the strategy proposed by the authors. PBL appears to work best in an undergraduate setting, and its primary function is to assist these students in developing their immature systems of learning and group functioning. Indeed, there is often a fall in the activity of the group once these skills have developed. Postgraduate students have a high level of core knowledge, and would have already consolidated their own learning techniques from the rigours of the undergraduate medical school curriculum. Moreover, the PBL scenario is precisely that – a scenario to mimic a situation which students may face in the future as practising clinicians. Basic surgical trainees are already qualified doctors, and it could be argued that the ultimate learning scenario is the experience of an actual clinical situation supported by the knowledge of a senior surgical trainee. Giving more ‘bleep-free teaching time’ would surely compromise this. Therefore, I would suggest to the authors that encouraging PBL as a learning medium for basic surgical trainees would in fact be a regressive step in the evolution of a surgeon.

Correspondence to: Mr G Singh Ranger, PBL Tutor, St George's Hospital and Medical School, Blackshaw Road, London SW17

Response on behalf of the authors by

Jonathan D Beard

North Trent Higher Surgical Training Scheme, Sheffield, UK

I thank Mr Gurpreet Singh Ranger for his comments, which I refute. He suggests that PBL appears to work best in an undergraduate setting, but this is because most of the research and application has been in an undergraduate setting. There is no research that I am aware of that compares the benefits of PBL for undergraduate versus postgraduate education. I also dispute his contention that postgraduate students have a high level of core knowledge and have already consolidated their own learning techniques. I agree that surgical trainees may have more knowledge, but this knowledge is often unstructured and poorly linked to basic surgical principles. The problem based learning tutorial was conducted in the same 8-step manner as used for undergraduate trainees, the same roles were adopted within the group and learning objectives (knowledge, skills and communication) were identified, as well as resources for further learning. A questionnaire was given to the attending SHO's and all found the tutorials a useful experience. The reasons given for this included sharing and contributing of information, discussing real-life problems which often seem ambiguous, and the opportunity to review the evidence base. All preferred PBL to the conventional Friday teaching sessions and indicated that they would like it applied to the rest of the curriculum. A

PBL tutorial is no substitute for an actual clinical situation but not all basic surgical trainees will be involved in the management of a patient with acute leg ischaemia. Problem-based tutorials are no substitute for clinical experience but they do complement it and seem an advance on an unstructured tutorial or slide show. A bleep-free environment is required for any teaching session, whether PBL or not.

Correspondence to: Mr J.D. Beard, Consultant Vascular Surgeon, Northern General Hospital, Herries Road, Sheffield S5 7AU.
Email: Jane.Eyre@sth.nhs.uk

Response to a Technical Tip by *MF Caruana, SM Singh*

A simple, safe and effective method for laparoscopic port closure

Ann R Coll Surg Engl 2002; **84**: 280

WT Ng

Department of Surgery, Yan Chai Hospital, Hong Kong, China

While I commend the authors for reporting a novel use of dental awls to close a trocar wound, I must point out that exactly the same procedure has been described, albeit using slightly different instruments, at least twice, several years ago.^{1,2} All these methods have two things in common. First, they make use of a needle-tipped instrument with a distal eyelet to carry a suture through all the layers of the abdominal wall. The intra-abdominal end is then withdrawn through the abdominal wall on the opposite side of the trocar by threading it through the eye of the same, but re-positioned, awl as pioneered by the present authors, or using special retrieval needles, namely, the Reverdin suture needle (Aesculap, Tuttlingen, Germany) and the Macial suture needle (Core Dynamics, Jacksonville, FL, USA) as advocated by previous authors.^{1,2} These suture needles, incorporated with a distal suture-trapping device, are designed to spare the surgeon the trouble of manipulating the suture thread into and through a pinhole laparoscopically under two-dimensional vision. They are additional purchase items. However, at institutions where a large number of laparoscopic procedures are performed, these re-usable needles would rapidly become a justifiable investment – at least, the general surgeons do not have to borrow awls from their dental colleagues, perhaps several times a day, whilst risking being complained for blunting the instrument.

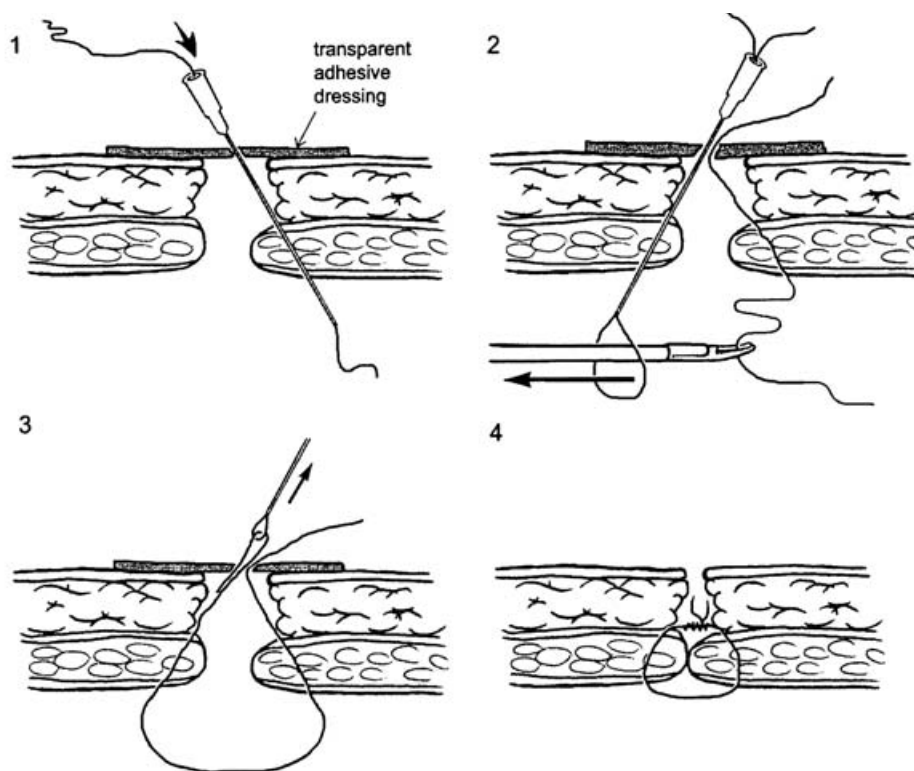


Figure 1 Steps of the angiocatheter port-closure technique. Arrows indicate direction of motion. Computer graphics by Mr KC Kong.

Second, they all involve insinuating a robust instrument between the skin incision and the in-dwelling cannula. When the skin incision is a tight fit (as is often the case for better cosmesis), it has to be enlarged to allow movement of the instrument, as well as placement of the pointed tip in the deep subcutaneous fat so that the resulting knot would be deeply buried and would not distort the wound skin surface on tightening the closing suture. Also, the thick shaft of the cannula hampers angling of the rigid instrument to get a good bite of all the musculoaponeurotic layers, especially in obese patients. Therefore, I have modified the technique by first removing the cannula from the abdominal wall to make the subsequent procedure easier, more elegant, and cosmetically more favourable. The porthole is covered with a transparent adhesive dressing (Tagaderm, 3M Health Care, St Paul, MN, USA) to maintain the pneumoperitoneum at around 12 mmHg. The suture needle can be accurately directed to puncture the midpoint of one side, and then the other side, of the fascial defect at an optimal angle without hindrance. Furthermore, if the aforementioned commercial products have not been procured and maxillofacial instruments are not available in the general surgery theatre, a common 14-gauge angiocatheter can be readily used to aid in the passage of the fascial suture and the insertion of another folded suture

(through the same angiocatheter angled in the opposite direction) to form a loop intra-abdominally to ensnare the fascial suture end. The loop with the entrapped suture is then pulled upward through the abdominal wall (Fig. 1). Originally, we grasped the suture end and pushed it through the loop.³ After reading the article, we now pass an endograsper through the loop, grab the suture end and pull it through the loop (Fig. 1).

In short, a port closure technique has evolved, which is simple, safe, quick and can easily be learned by residents.

References

1. Berguer R. A technique for full thickness closure of laparoscopic trocar sites. *J Am Coll Surg* 1995; **180**: 227–8.
2. Elashry OM, Nakada SY, Wolf JS, Fignshaw RS, McDougall EM, Clayman RV. Comparative clinical study of port-closure techniques following laparoscopic surgery. *J Am Coll Surg* 1996; **183**: 335–44.
3. Ng WT. An improved, inexpensive, quick, and easily learned technique for closure of all large abdominal trocar wounds after laparoscopic procedures. *J Am Coll Surg* 2003; In press.

Correspondence to: Prof. WT Ng, Consultant and Chief of Service, Department of Surgery, Yan Chai Hospital, 7-1 1, Yan Chai Street, Tsuen Wan, Hong Kong, China. E-mail: houstonn@yahoo.com

*Response on behalf of the authors by***Surjat Singh**

Department of Surgery, Queen Elizabeth Hospital, King's Lynn, Norfolk, UK

We are most grateful to Prof. Ng for showing an interest in our article and for his comments. We agree entirely that similar principles of port closure, albeit using instruments other than dental awls, have been described before. Some were listed as references to our article. The Kings Lynn & Wisbech Hospitals NHS Trust, like all others in the UK, is grossly overspent and has no budget available to 'spare the surgeon the trouble of manipulating the suture thread into and through a pinhole laparoscopically under two-dimensional vision'. The dental awls we use had been discarded by our maxillofacial surgeons. We are not aware of having blunted any after 200 or so uses. Whilst we agree with the theoretical difficulties outlined by Prof. Ng of insinuating a robust instrument accurately alongside a tightly fitting cannula, these can be overcome. We withdraw the cannula momentarily to allow easy access into the depth of the port site incision. The pneumoperitoneum is maintained as long as the cannula is not withdrawn completely. The awl is only pushed through the muscle layers under direct vision for accurate positioning. Slight angling of both the cannula and the dental awl avoids the two instruments obstructing each other. We were pleased to read of Prof. Ng's modification. Before settling on the humble dental awl, we had experimented with crotchet hooks (described by Roger Motson, Chelmsford, UK), Spinal needles and, indeed, 12-F and 14-F angiocatheters as suture carriers across the abdominal wall. We found that the diameter of the suture carrier limited the gauge of the suture that could be passed as a loop through it. With the dental awl, sutures of '0' or '1' can be easily used. In these days of increasing pressures on the operating lists to get more cases done and diminishing hours available for our junior colleagues to master surgical skills, this technique offers valuable learning opportunities. The port closure becomes an integral part of the laparoscopic procedure, the anaesthetist (perhaps reluctantly) maintains muscle relaxation and the trainee can play an active role in the operation. Most of our trainees have found it valuable and look upon it as a personal challenge to do better than their predecessors, as adjudged by the theatre scrub nurses!

Correspondence to: Mr Surjat Singh, Consultant General Surgeon, Queen Elizabeth Hospital, King's Lynn, Norfolk, UK.
E-mail: surjat.singh@qehkl.nhs.uk

*Response to paper by AD Gilliam et al.***Finding the best from the rest: evaluation of the quality of patient information on the Internet**

Ann R Coll Surg Engl 2003; **85**: 44–6

Thalia Knight

Head of Library & Information Services, The Royal College Of Surgeons of England, London, UK

The results of the survey carried out by Gilliam *et al.* come as no surprise to health information professionals who have been concerned about this issue since the early days of the development of the World Wide Web. In the UK, this led to the setting up of the OMNI service (Organising Medical Networked Information) based at the University of Nottingham as long ago as 1995.¹ By coincidence, I wrote an article on patient information for the February 2003 issue of the *Bulletin of The Royal College of Surgeons of England*.² In it, I draw attention to the resources created on the College web site for patients³ that have been checked by the College's information professionals using OMNI criteria. Help with learning how to assess the quality of health information on the Internet has been addressed in our 'Health Information on the Internet for Surgery Patients' section and I would especially like to draw your attention to an excellent resource produced by the Centre for Health Information Quality (CHIQ), with funding from the Department of Health, called 'Hi Quality' <<http://www.hiquality.org.uk/>>. This College patient information resource goes a long way to meeting the need for relevant patient information and addresses the conclusion drawn by Gilliam *et al.* that 'recommended web-sites that provide the best information would help patients avoid being overwhelmed with irrelevant and confusing literature'. Please take a look – we would be interested to hear from any readers who might have comments to make.

References

1. See <<http://omni.ac.uk/>>.
2. *Bull R Coll Surg Engl* 2003; **85** (Suppl): In press.
3. See <http://www.rcseng.ac.uk/welcome/information_for_patients/>.

Correspondence to: Thalia Knight, Head of Library & Information Services, The Royal College of Surgeons of England, 35–43 Lincoin's Inn Fields, London WC2A 3PE, UK.
E-mail: tknight@rcseng.ac.uk

Response to paper by

S Madan, S Sekhar, NJ Fiddian

Wroblewski wedge augmentation for recurrent posterior dislocation of the Charnley total hip replacement

Ann R Coll Surg Engl 2002; **84**: 399–403

John J Atkinson, Mark R Webb, Martyn E Lovell

E-mail: martynlovell@aol.com

We were pleased to see the report of the extensive series of augmentation procedure for dislocating hip replacements. We would, however, recommend that the authors move from the Wroblewski wedge to the posterior lip augmentation device (PLAD: De Puy, UK), which as well as having five screws also has metal re-inforcement such that it will not fail by disruption which was indicated as a problem in their series. Regarding minor impingement and loosening, we are not sure that this should be a problem and would suggest that there is now evidence that constraint for dislocation with a more extensive capture cup is safe.¹ If very poor abductors are found, we use the augment in a capture position, and have also found that our population is very elderly with the majority being octogenarians. Although our series of 16 is not as extensive as the report in the article by Madan *et al.*, our follow-up is a mean of 32 months with one failure. We also find that we can achieve augment placement through a limited posterior approach, which as well as being quick in terms of surgical time causes little inconvenience to the patient. We would recommend this method unless gross wear or malpositioning of components is found.

Reference

1. Goetz DD, Capello WN, Callaghan JJ, Brown TD, Johnston RC. Salvage of total hip instability with constrained acetabular components. *Clin Orthop* 1998; **355**: 171–81.

Response on behalf of the authors from

NJ Fiddian

The Royal Bournemouth Hospital, Bournemouth, UK

I appreciate the interest expressed by Mr Lovell and his team and I would make the following comments with regard to the points which they raised:

1. Our article is very much now historical in the sense that the patients under review were treated several years ago. We have in fact been using the PLAD rather than the Wroblewski wedge for the last few years and we would agree that it is a far superior augmentation device.
2. We would agree that impingement on and loosening of the acetabular component as a result of using an augmentation device is largely theoretical rather than proven and we continue to be very happy to use the PLAD in the elderly recurrent dislocater.
3. We use a posterior approach for our primary total hip replacements and so we too insert the augmentation device through a limited posterior approach without difficulty.

Correspondence to: Mr NJ Fiddian, Consultant Orthopaedic Surgeon, The Royal Bournemouth Hospital, Castle Lane East, Bournemouth BH7 7DW, UK

Errata

We apologize for the following omissions in the November issue and any inconvenience caused.

Ann R Coll Surg Engl 2003; **85**: 'Contents list'.

Patient attitudes to the Internet and analysis of the potential role of a dedicated colorectal website – a prospective study

David Birchley, Rupert Pullan, David DeFriend pp398–401

The above paper was not included in the contents list.

Ann R Coll Surg Engl 2003; **85**: p444

Letter: **The fourteen-day rule and colorectal cancer**

The references and contact address at the end of this letter were omitted. These are given below.

References

1. Walsh S *et al.* The fourteen-day rule and colorectal cancer. *Ann R Coll Surg Engl* 2002; **84**: 386–8.
2. Selvachandran SN *et al.* Prediction of colorectal cancer by a patient consultation questionnaire and scoring system: a prospective study. *Lancet* 2002; **360**: 278–83.
3. Stubbs R, Long M. Symptom duration and pathologic staging of colorectal cancer. *J Surg Oncol* 1986; **12**: 127–30.
4. Jones R, Rubin G, Hungin P. Is the two week rule for cancer referrals working? *BMJ* 2001; **322**: 1555–6.

Correspondence to: Mr D Cade, Leighton Hospital, Middlewich Road, Crewe, Cheshire CW1 4QJ, UK.

Tel: +44 1270 255141; Fax: +44 1270 587696; E-mail: david.cade@mcht.nhs.uk