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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.

Response to paper by L Deliss

Designing a basic surgical timetable

Ann R Coll Surg Engl 2003; **85**: 420–1

Stephen Blair

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There seems to have been a major error here. This has been put out as a model for timetables which says that it meets working time needs. This is totally wrong and it would be a disaster if people thought that this had College approval. The European Working Time Directive comes into effect by August 2004. This states very clearly that no-one may work more than 13 hours in a 24-hour period. The programme recommended by Louis Deliss totally ignores this. A morning off after 24 hours of work is completely inadequate as compensatory rest. It should be 11 hours and it counts as work time. The hours of duty that he recommends add up to the equivalent of 70 hours per week including prospective cover. It should be less than 56 hours. He is, therefore, recommending an already illegal rota.

Response from the author

Louis Deliss

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I am sorry my paper upset Mr Blair. I believe that it can be the basis for an SHO timetable that complies with the European Working Time Directive or at least much more closely than the majority I have seen as an HRC visitor. My object in writing the paper was to stimulate open discussion rather than let each hospital trying to work it all out alone. I accept full responsibility and the Editor never accepts that the views expressed in the *Annals* are 'official'. If my paper causes others such as yourself to make public better solutions I would count it a success.

Response to paper by SE Tranter & MH Thompson

Spontaneous passage of bile duct stones: frequency of occurrence and relation to clinical presentation

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We note in the authors' results that patients with evidence of duct stones who presented jaundiced had an average bilirubin of 97. We would agree that this figure is associated with common bile duct (CBD) stones based on our own study of bilirubin levels in patients presenting for endoscopic retrograde cholangiopancreatogram (ERCP). Our results showed an average total bilirubin of 109 in patients who were later found to have CBD stones at ERCP. We note that the authors are using a protocol to predict CBD stones[1] that uses a raised bilirubin as one of its criteria. We would add a caveat to this based on our study. A raised bilirubin > 150 is invariably due to malignant disease with a specificity of 86% even if gallstone disease is also present.

Reference

1. Welbourn CRB, Haworth JM, Leaper DJ, Thompson MH. Prospective evaluation of ultrasonography and liver function tests for preoperative assessment of the bile duct. *Br J Surg* 1995; **82**: 1371–3.

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Response to paper by M Bradley et al.

The groin hernia – an ultrasound diagnosis?

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Ultrasound diagnosis of round ligament varicosities mimicking inguinal hernias in pregnancy

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One key area that was omitted from this article was the differential of varicosities of the round ligament of the uterus presenting during pregnancy. This condition is easily misdiagnosed as an obstructed hernia resulting in an unnecessary operation during pregnancy.[1–3] As demonstrated in Figure 1, the correct diagnosis of varicosities of the round ligament of the uterus is very apparent on ultrasound. In our two cases both the patients presented in the third trimester of pregnancy. Once the diagnosis was confirmed on ultrasound, both patients were re-assured that the condition could be treated non-surgically and that it would not affect a normal vaginal delivery. After childbirth, the swellings resolved spontaneously.

Review of the literature revealed four cases of round ligament varices presenting during pregnancy. In two cases,[1,3] the diagnosis was made intra-operatively. In the other two cases[2,3] the diagnosis was made with ultrasound and no surgery was performed.

Figure 1 Soft tissue ultrasound revealing multiple dilated veins in round ligament of uterus extending from deep inguinal ring through inguinal canal. No evidence to suggest a hernia. Appearances consistent with round ligament varicosities.

To avoid making the diagnosis of round ligament varices during unnecessary surgical exploration, we recommend ultrasound examination in all cases of groin lumps presenting during pregnancy.

References

1. Guillem P, Bounoua F, Duval G. Round ligament varicosities mimicking inguinal hernia: a diagnostic challenge during pregnancy. *Acta Chir Belg* 2001; **101**: 310–1.
2. Cheng D, Lam H, Lam C. Round ligament varices in pregnancy mimicking inguinal hernia: an ultrasound diagnosis. *Ultrasound Obstet Gynecol* 1997; **9**: 198–9.
3. Al-Qudah MS. Postpartum pain due to thrombosed varicose veins of the round ligament of the uterus. *Postgrad Med J* 1993; **69**: 820–1.

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Response to paper by RB Galland

Nineteenth century amputations at the Royal Berkshire Hospital, Reading

Ann R Coll Surg Engl 2003; **85**: 393–5

Amputations at St Thomas' Hospital 1862–1869

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I would like to contribute the results of a review of amputations at St Thomas' Hospital during 1862–1869. During the first four years of that period (1862–1865), there were 57 amputations with 24 deaths. The next four years (1866–1869) saw a near halving of the mortality rate – 10 deaths in 41 operations.[1] Amputations, as classified at that time, were performed for three main reasons – primary, secondary or disease-related (see Table 1).

The mortality rates at St Thomas' were slightly higher than at Reading (see Table 2), yet they were comparable to contemporary large metropolitan hospitals. Controversial debate at the time highlighted different mortality rates between 'private rooms' and large hospitals (1:9.2 versus 1:2.4 in one study and a reverse relationship at St Bartholomew's 1:3.6 versus 1:5.8). St Thomas' improved latter period, however, was actually during its residence in temporary buildings at Surrey Gardens Music Hall, deemed inappropriate and 'defective'. These numbers

Table 1 Amputation aetiology and statistics

Reason for amputation	Number	Deaths	Mortality
Primary (for trauma)	41	10	1:4.1 (24%)
Secondary (to pyaemia, exhaustive suppuration, secondary haemorrhage	16	8	1:2 (50%)
Limb related disease (*e.g.* gangrene, necrosis, caries infection, encephaloid, myeloid tumour)	39	7	1:5.5 (18%)

Table 2 Upper and lower limb mortality in the two periods at St Thomas' Hospital

	1862–1865	1866–1869	Total (1862–69)
Upper limb mortality	3:23 (23%)	3:15 (20%)	6:28 (21%)
Lower limb mortality	21:44 (48%)	7:26 (27%)	28:70 (40%)

may support the nature of the buildings as part of the multifactorial nature of hospital-related mortality; although temporary, the Surrey Gardens site was clean and infection-free. However, the improved rates also had much to do with two interventions introduced circa 1865: (i) the partial introduction of carbolic acid antisepsis; and (ii) the application of exclusion criteria, especially in those patients suffering from suppurating sores.

Reference

1. Churchill F. Amputation statistics. *Saint Thomas's Hospital Reports* 1870; **1**: 503–4.

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Response to paper by SR Bramhall et al.

Liver resection for colorectal metastases

Ann R Coll Surg Engl 2003; **85**: 334–9

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We read with interest the article of the audit of colorectal cancer liver metastasis resection performed at the Liver Unit in Birmingham, UK. The need for more effective patient selection being offered this treatment modality was emphasised. The policies at Washington University in St Louis mandate that patients considered for liver resection or radiofrequency ablation for the treatment of colorectal metastasis must be staged pre-operatively with CT scanning and positron emission tomography using [^{18}F]-fluoro-2-deoxy-D-glucose as a metabolic marker of malignant cells (FDG-PET). FDG is trapped inside the cell and accumulated at a more rapid rate in proliferating cancer cells.

We have previously shown that this technique is more sensitive than conventional CT and can alter the management of such patients.[1] In addition, the use of pre-operative staging FDG-PET scans has resulted in a 3-year survival rate of 77% in patients with resectable liver metastases due to more accurate patient selection.[2] We accept that the use of MRI in defining both liver and distant metastasis is more accurate than CT, and was also used in this study, but there is evidence to suggest that FDG-PET is more accurate than both these modalities.[3] We, therefore, suggest that the authors consider the use of FDG-PET in their algorithm for managing patients with metastatic colorectal cancer.

References

1. Whiteford MH, Whiteford HM, Yee LF, Ogunbiyi OA, Dehdashti F, Siegel BA *et al*. Usefulness of FDG-PET scan in the assessment of suspected metastatic or recurrent adenocarcinoma of the colon and rectum. *Dis Colon Rectum* 2000; **43**: 759–67.
2. Strasberg SM, Dehdashti F, Siegel BA, Drebin JA, Linehan D. Survival of patients evaluated by FDG-PET before hepatic resection for metastatic colorectal carcinoma: a prospective database study. *Ann Surg* 2001; **233**: 293–9.
3. Anderson GS, Brinkmann F, Soulen MC, Alavi A, Zhuang H. FDG positron emission tomography in the surveillance of hepatic tumors treated with radiofrequency ablation. *Clin Nucl Med* 2003; **28**: 192–7.

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Response on behalf of the authors

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We agree that CT scanning with positive emission tomography (FDG-PET) offers significant potential in the staging of patients prior to surgery for metastases from colorectal cancer. This technique is, however, not widely available in the UK although in our own

institution we have recently acquired the use of an FDG-PET scanner and are likely to have access to CT scanning with FDG-PET in the near future. I would, however, point out that the data on which the paper was based dated from March 1989 to March 2001 and. therefore. during this period there was no access to this type of imaging. Once this technique is widely available, we will of course evaluate its use as point of our algorithm for the management of these patients.

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Response to paper by Mark Sheldon Lloyd

Matador versus taurus: bull gore injury

Ann R Coll Surg Engl 2004; **86**: 3–5

MKH Crumplin

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Two hundred years ago, in the absence of traffic trauma, there was, in Britain, 5–10% mortality from wounds or diseases inflicted by animals. The great French surgeon Baron Jean Dominique Larrey, accompanying Bonaparte's only foray into Spain in 1808, to eject Sir John Moore's army witnessed a bullfight in the city of Burgos. A drunken soldier, trying his hand as a matador, entered the bullring and, whilst kneeling, was gored by a bull in his right buttock. Larrey ran down and took him to hospital. The horn had curved round and entered the groin, tearing muscles and wounding the detrusor. Larrey explored the wound and was met by a hernial protrusion of the bladder mucosa.[1]

He then 'laid open the internal wound, and introduced a probe along its track for the purpose of detaching that part of the integuments of the groin which covered the hernial protrusion, incising the projecting point of the skin and laid bare the whole tumour. Previously to attempting its reduction, I took care to introduce a gum elastic catheter into the bladder, in order to remove its contents, suffering it to remain in this position. The displaced portion of this membranous sac was then reduced, the urine being gradually forced at the same time into its proper cavity. The patient immediately became calm, and from that moment we entered great hopes of his recovery.' Larrey found him cured 6 months later. This case reminds us of bladder injury and of as successful a management as was possible at these times, free drainage of the wound and prolonged catheterisation, the latter being far from simple.

Reference

1. Baron DJ Larrey. *Of the Campaigns of Russia, Germany and France*. 1832; p 179.

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Response to paper by AJ Eccersley et al.

Referral guidelines for colorectal cancer – do they work?

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The authors showed that the guidelines for urgent referral in suspected colorectal cancer cases benefit only one in five patients, with a large number of cases diagnosed from non-urgent referrals. We certainly agree with the authors that education of the community is an essential component in improving early presentation. We would like to refer readers to the paper published by Harinath *et al*.,[1] which showed that the guidelines published by the Association of Coloproctology of Great Britain and Ireland (ACPGBI) have a low sensitivity. The authors suggested the following modifications: (i) a palpable mass anywhere in the abdomen (ACPGBI: a palpable right-sided abdominal mass); (ii) reducing age threshold from > 60 years (ACPGBI) to > 50 years; and (iii) new criteria introduced – weight loss with abdominal pain (not included in ACPGBI guidelines). Though revision of the guidelines increases the number of urgent referrals to the clinic, it does result in increasing the sensitivity of criteria from 82% to 94%. We feel that these modifications to the Department of Health criteria are justified as they result in greater pick-up of colorectal cancers from the clinic.

Reference

1. Harinath G, Somasekar K, Haray PN. The effectiveness of new criteria for colorectal fast track clinics. *Colorectal Dis* 2002; **4**: 115–7.

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