

Table I

Series	GA or sedation	X-ray	Number	Perforation	Mortality
Atkinson <i>et al.</i> (1978)					
Bennett <i>et al.</i> (1981)	GA or sedation	Yes	820	9	?
Watson (1982)	Sedation	Yes	32	9	15.6
Gasparri <i>et al.</i> (1987)	GA or sedation	Yes	248	2	7.6
Bueset <i>et al.</i> (1987)	Sedation	Yes	144	7.8	4.3
van den Brandt-Gradel <i>et al.</i> (1987)	Sedation	Yes	400	7	4
Bramhall <i>et al.</i> (1993)	GA	No	50	20.8	12
Our series	Sedation	Yes	50	4	6

acceptably low rates of perforation (*see* Table I). In our last 50 intubations our perforation rate has been 4%. There are several other available palliative techniques which are safe (2).

Before changing to a technique with less control, operators should be sure that it offers true advantages in the desired end results—quick, effective and safe restoration of adequate swallowing.

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#### Gunshot wounds of the colon: ballistic considerations

While I agree with Gregori's assertion (*Annals*, May 1993, vol 75, p214) that some gunshot wounds to the colon are amenable to primary repair, I must take issue with his views on ballistics. He follows what Lindsey called 'the idolatry of velocity' (1) and further clouds the issue with a misleading statement on the velocity of bullets from various weapons.

The crucial matter determining the damage caused by a bullet is not its velocity but the energy which it transfers in its path through the tissues. This is determined by the tissues encountered as well as the ballistic characteristics of the weapon (2). For example, the wound track through skin and muscle is associated with much less damage than when bone is struck. In the latter case, far more soft tissue is injured, in addition to the bony damage, since the bullet is rapidly retarded, destabilised and possibly fragmented in the tissues, giving up more energy. Bullets from some weapons have a tendency to become unstable earlier than others in their track through tissue; this contributes to their energy transfer and hence the extent of tissue damage

(3). It is the latter phenomenon which accounts for the differences in injury seen in some wounds from the AK47 ('Kalashnikov') compared with the M16 ('Armalite').

It is misleading of Gregori to label the AK47 as a low-velocity weapon. Its muzzle velocity (around 720 m/s) is less than that of the M16 (around 900 m/s) but is far greater than the velocity of the handgun bullets conventionally regarded as being 'low velocity' (less than 300 m/s).

All of that being said, what does it matter to the surgeon? Not much—for in many cases the weapon is unknown, but the injury can be assessed clinically. Hence, if the extent of bowel disruption is felt to be compatible with primary repair then this approach may be followed (4), regardless of the mass or velocity of the projectile which has caused the injury. It is worth reiterating that surgeons should assess, and treat, the wound not the presumed weapon.

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#### Benign thyroid disease and vocal cord palsy

Rowe-Jones *et al.* (*Annals*, July 1993, vol 75, p241) have rightly emphasised the importance of preoperative laryngeal assessment prior to thyroid surgery. Further, the apparent relationship of preoperative paresis to benign thyroid disease is illustrated well and evaluated. However, although depicting two patients as having an alternate paralysis (1), no attempt has been made to explain this unusual finding. Certainly, in one patient, the concept that a relatively rigid trachea is deviated by the solitary lesion against a somewhat resistant contralateral thyroid lobe leading to nerve compression is supported by one case, but not the other. In both recovery, and non-recovery groups, it is possible that some of the pareses may have been due to idiopathic paralysis (2) totally unrelated to the thyroid disease. In this situation it was shown that recovery, as well as a persistent paralysis, could occur, a possibility discussed in detail elsewhere (3).

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