

abdominal injuries). Operation usually within one hour". From reading the paper it would seem that a number, if not the majority of the patients reported, were not 'emergencies' according to these criteria. That is not to say that they were not 'urgent' operations, defined in the CEPOD report as "delayed operation as soon as possible after resuscitation (eg intestinal obstruction, embolism, perforation, major fracture). Operation usually within 24 hours."

Clearly, by definition there can be no significant delays in operating on 'emergencies' as defined by CEPOD, otherwise the patient will not survive. 'Urgent' cases are a different matter, however, and we would like to ask the authors to produce an analysis of their 'urgent' cases, as this information is needed in order to make an assessment of whether the patients are likely to have been adversely affected by the median delay of only 3 h reported.

While in an ideal world all 'urgent' patients would have their operations immediately after it is decided to be necessary, in practical terms this is never going to be possible, and the surgical community should be deciding what levels of delay are and are not acceptable for different types of patients.

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Reference

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The presentation of malrotation of the intestine in adults

I would like to add a word of caution to the otherwise excellent article of Gilbert *et al.* (*Annals*, July 1990, p239).

Adult malrotation can mimic intestinal obstruction on X-ray appearance while, in fact, not being responsible for the cause of the patient's abdominal pain (1).

If unrecognised, this may lead to unnecessary laparotomy. Malrotation may be associated with other abnormalities, eg hypoplastic right lung (1). The presence of such physical features should alert the surgeon to this potential pitfall. Furthermore, a common association of adult intestinal malro-

tation is the 'cocoon' deformity, where the small gut is encased in a filmy peritoneal sac. This also often creates the X-ray pattern described above and again may result in unnecessary surgery (1).

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- 1 Banerjee AK. Intestinal malrotation—a missed diagnosis. *Practitioner* 1989;233:468–71.

We were interested to read the paper by Gilbert *et al.* (*Annals*, July 1990, vol 72, p239) and would like to draw their attention to another rare presentation of this condition, not previously described in adults. Our patient was a 60-year-old male who presented with small bowel obstruction. A barium enema 4 years previously had shown failure of descent of the caecum, which was situated in the right upper quadrant of the abdomen. At laparotomy he was found to have a gangrenous ileocolic intussusception and underwent right hemicolectomy. A relationship between these two congenital conditions was first described in three children by Waugh in 1911 (1). The importance of this association remained unrecognised until recently when Brereton *et al.* (2) reported that 41 of 49 cases of infant intussusception undergoing laparotomy had a degree of malrotation, most commonly an unfixed caecum. They postulated that malfixation of the ileocaecal mesentery may allow the terminal ileum to pass into the caecum, resulting in intussusception and coined the term 'Waugh's syndrome'. We have researched the literature and can find no report of this condition presenting in adult life.

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- 2 Brereton SJ, Taylor B, Hall CM. Intussusception and intestinal malrotation in infants: Waugh's syndrome. *Br J Surg* 1986;73:55–7.