of view, I feel it would be useful if the authors could break down their figures for abdominal aortic aneurysm surgery into the three groups I mention and also confirm that thoraco-abdominal aneurysms are not included in this classification mentioned in Table V.

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Authors' reply

We would like to thank Mr Clyne for his comments, which we fully endorse. Obviously audits such as this generate vast amounts of data and there is always a compromise between a manageable article and loss of detailed data. In addition our data suggests no difference in complication rates between tender and asymptomatic aneurysm repair.

Thoracoabdominal aneurysms were included in Table V. The breakdown of our figures as suggested by Mr Clyne is as follows:

	Asymptomatic aneurysm ($n=60$)	*Tender aneurysm* ($n=23$)	*Thoraco-abdominal aneurysm* ($n=8$)
Mortality	3 (5)*	1 (4)	2 (25)
Haemorrhage	2 (3)	0	1
Distal embolus	1 (2)	0	0
Occlusion	0	1 (4)	0

* Figures in parentheses are percentage

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Erratum

In Table V of the article, an error occurred in the final draft of the manuscript as follows:

Under the column heading *Aortic aneurysm – Asymptotic or tender*, the numbers should be $n=91$ *and not* $n=98$ as printed.

A comparison of danazol and placebo in the treatment of adult idiopathic gynaecomastia: results of a prospective study in 55 patients

We read with interest the paper by Jones *et al.* (*Annals*, September 1990, vol 72, p296) comparing danazol and placebo in the treatment of adult idiopathic gynaecomastia (IAG).

The clinical term 'gynaecomastia' is used to describe two conditions: a well-defined, firm and often tender enlargement of the breast disc or a less defined, more diffuse fatty breast seen as part of a generalised increase in subcutaneous body fat. May we assume that the authors have entered only the former.

While we would support interest in the non-operative management of IAG, some details in this paper are of note. It would be more valuable to the reader if minimal, moderate and severe as used to describe the degree of gynaecomastia and severity of breast tenderness were defined. The measuring of breast enlargement consistently to 1 mm is commendable, but to describe size changes up to 1/100th of a centimetre is rather less credible. Also a 'significant P value' is given for the mean ages of the two groups—this suggests that the study and control groups were representative of two different populations, which in itself would invalidate the conclusions.

The substance of this paper hinges on the statistical analyses showing an improvement in the degree of gynaecomastia between the control and study groups with $P<0.05$; this is despite two men in the study group progressing to marked gynaecomastia. Danazol reduces rather than resolves AIG but may nevertheless be useful in reducing the subsequent need for surgery. We would like to see this study continued, thereby increasing its statistical power.

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McBurney's point—fact or fiction?

I read with interest the above paper (*Annals*, September 1990, vol 72, p304) which points out how an eponymous sign can be accepted into traditional surgical teaching with no more than 'anecdotal' evidence. I would, however, take issue with the statement that "incisions for appendicectomy should be lower . . .". Placing an incision low down in the right iliac fossa is a potent cause of difficulty in removing the appendix and is not the advice that should be given to the relatively junior surgeons who most commonly perform this operation.

It may be very difficult to deliver the caecum from the depths of a capacious abdomen through a low incision, since it needs to 'hinge' upwards from the posterior abdominal wall to lie at a higher level on the surface. The caecum may be traumatised and a poor view of the mesoappendix is obtained with risk of inadvertent damage to the adjacent bowel or poorly applied ligatures. Escape from these problems may require an assistant, which may be a luxury in the middle of the night.

The traditional gridiron incision allows even a high caecum to be gently delivered onto the surface of the abdomen where it will sit comfortably without tension and with an excellent view of the base of the appendix. The mesoappendix is safely ligated and, if a Z stitch is used instead of a pursestring, the appendix stump becomes 'self invaginating'. At no time is an assistant required and the operation is rendered safe and straightforward.

A further point is that the basic philosophy in deciding to operate on a patient with a presumptive diagnosis of 'appendicitis' should be that of 'laparotomy for right iliac fossa peritonism'—we are still far from being correct in every case. The required incision is that through which adequate and extensible access is gained to the right iliac fossa, not one that seeks to enter the abdomen immediately over the base of the appendix; indeed this paper has shown that this is variable, and it cannot be predicted preoperatively. The gridiron incision admirably suits the criteria of access and extensibility and can easily be extended into the flank by splitting muscle fibres apart and will skirt the anterior superior iliac spine. Though high it can still be extended into a Pfannenstiel incision if pelvic pathology is detected.