

## Catheterisation for nephrectomy

In your Comment Section (*Annals*, July 1990, vol 72, p272) I notice that Alphose Pfau, Head of Urology, Hebrew University, was interested in a paper by Davies *et al.* (*Annals*, November 1989, vol 71, p368).

Professor Pfau considered postoperative bladder catheterisation in postoperative urinary retention to be 'cavalier'.

I agree with him to a certain extent but only in so far that almost all cases of postoperative urinary retention in males are due to prostatic obstruction. If a proper history and a proper physical examination are taken and, if necessary, cystourethroscopy is done in elective cases, the prostate can be attended to if there is obstruction present before the other surgery, be it nephrectomy, gastrectomy or whatever else is to be operated on. If this is done it is extremely unlikely that postoperative retention of urine will occur. However, should the surgical procedure necessitate careful examination of urinary output to monitor fluid balance, the insertion of a catheter into the urethra is really no problem in a well-managed setting. If the catheter is required for a long time then there is no problem with a stab cystostomy.

I really feel that Professor Pfau is making much ado about very little in considering urethral catheterisation an invasive procedure in the business of prostatic obstruction.

I do not include in this small Comment any opinion of catheterisation after gynaecological surgery, which I consider to be of course a completely different world, and which as we all know after gynaecological anterior repair is often associated with residual urine and infection.

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## The response of general surgeons to HIV in England and Wales

We should like to question the assertion made by Stotter, Vipond and Guillou (*Annals*, September 1990, vol 72, p281) that, in HIV positive patients, symptoms and signs suggesting acute appendicitis "are likely to be HIV related and an unnecessary laparotomy in a patient with CMV colitis, TB or cryptosporidiosis has a high morbidity and mortality with little or no benefit". The paper cited in support of this statement (1) included no patients who presented with right iliac fossa pain, but did include two patients with cytomegalovirus perforation of the ileum and colon, in whom laparotomy was clearly not unnecessary but essential.

In the last 18 months we have operated on three HIV positive men who presented with signs of peritonitis localised to the right iliac fossa. In the first of these, our uncertainty as to the significance of these signs in a patient with HIV led us to keep the patient under observation for over 24 h before removing a grossly inflamed appendix. The second patient presented with classical features of acute appendicitis and, on the basis of our earlier experience, we operated on him without delay. A macroscopically and histologically inflamed appendix was removed.

The third patient in our series was not known to have HIV at presentation. At operation he was found to have inflammation of the terminal ileum which was thought at the time to represent Crohn's disease. An ileocaecal resection and anasto-

mosis was done. Histology subsequently showed patchy, full-thickness infarction of the bowel wall, suggesting that perforation had been imminent. In retrospect, it seems likely that this patient had cytomegalovirus (CMV) enteritis.

This last patient resembles two in Ferguson's series (1) except that, in his patients, the bowel had perforated before operation. His patients experienced serious postoperative complications, one of them dying, whereas ours made an uncomplicated recovery, HIV infection being diagnosed shortly afterwards. Our patients with appendicitis also made satisfactory recoveries, although both had several days of postoperative pyrexia, treated with broad-spectrum antibiotics, before settling.

The presence of a Regional Infectious Diseases Unit in our hospital makes it likely that we shall see an increasing number of HIV infected patients with acute abdominal signs. We do not know how many similar patients have been seen by the physicians and not referred to us but, of the three who have been referred so far, all proved to have acute surgical conditions requiring urgent laparotomy. In immunocompromised patients it is clearly desirable that such conditions should be treated at an early stage and we suggest that such patients should be operated on no less promptly than those who are seronegative.

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## Reference

1 Ferguson CM. Surgical complications of Human Immunodeficiency virus infection. *Am Surg* 1988;54:4-9.

## Local audit in vascular surgery

I enjoyed the above article by J P Roberts *et al.* (*Annals*, September 1990, vol 72, p287) and I was particularly interested in the mortality and morbidity following proximal vascular reconstructions. I am sure their figures for mortality are no different to many of us who carry out quite large volumes of vascular surgery. There will be many doyens who will no doubt throw up their hands in horror at seeing their mortality for elective aneurysm surgery over 10%, but I think if we all examine our figures over the past 2 or 3 years we would find that we are being offered and indeed have to undertake a vascular reconstruction, particularly for aortic aneurysm, in less than ideal patients. I also believe that it is now incumbent on any group reporting surgery for aortic aneurysm to list morbidity and mortality under the headings asymptomatic, urgent (tender or expanding), or ruptured.

There have been a number of publications recently illustrating the large increase in morbidity and mortality for those aneurysms that we tend to do of a rather more urgent nature even though they are not frankly ruptured.

Having said that, I was rather surprised to find in the penultimate paragraph of the discussion a mention of thoraco-abdominal aneurysms and I just wonder if these are included in the mortality and morbidity of aortic aneurysm surgery referred to in Table V.

As I think this paper is rather important from an audit point

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:

	<i>Asymptomatic aneurysm</i> (n = 60)	<i>Tender aneurysm</i> (n = 23)	<i>Thoraco-abdominal aneurysm</i> (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.