There were two anastomotic leaks (7%), while another two patients (7%) developed anastomotic strictures. These were treated successfully. The remaining complications were of a minor nature.

In summary, therefore, major complications occurred in 14% of patients undergoing reversal of Hartmann's colostomy. Various factors that have been implicated in the production of these complications have been discussed in detail elsewhere *(1)*.

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Reference

1 Khan AL *et al.* Reversal of Hartmann's colostomy. *J R Coll Surg Edinb* 1994; **39**: 239–42.

One-stop diagnosis for symptomatic breast disease

We read with interest the recent article by Gui *et al.* (*Annals*, January 1995, vol 77, p24), having introduced a consultant-led one-stop breast clinic, using almost identical methodology, in our hospital in April 1993. Auditing its performance during the first year, we found that 401 new patients were referred to this clinic, a figure which appears likely to at least double during the present (second) year of its operation, indicating the popularity of such clinics with GPs. The average time interval between GP letter and consultation was 13 days, less than that in the article, but still surprisingly long, considering that it was an open-access clinic.

The patients were almost equally divided between pre- (49%) and post-menopausal (51%) and 63% were in the prescreening age group. Mammography and/or ultrasonography was carried out on 72% of patients and 53% had fine needle cytology. A similar proportion of our patients were discharged after the first visit (33%) and 120 patients (30%) had further procedures (excision biopsy, wide local excision or mastectomy) carried out within 15 days, based on the decision made at the first visit. Analysis of the final diagnosis in our series also revealed malignancy in 8% of patients, three of which were interval cancers undetected at previous screening.

Although we have not as yet analysed the average time patients spend in clinic, we would agree with the findings of Gui *et al.* that in most cases it was between 2 h and 3 h. As we are a medium-sized DGH, with relatively manageable numbers of new referrals weekly, we are at present able to offer this service to all symptomatic breast patients. However, we appreciate the problems faced by those at hospitals such as St Bartholomew's with considerably larger numbers.

The necessity for mammography to precede cytology means that all new patients must be seen early in the clinic, which can in turn provide a sudden heavy radiological workload. We concur with Gui *et al.* that mammography is the most time-consuming element of the assessment and seems to be the limiting factor with regard to the number of new patients which it is possible to assess at any one clinic. The solution which we have adopted for the increasing number of new referrals is simply to have an additional clinic during a different session, which spreads the workload for all involved, particularly radiology, and allows unhurried final consultation between patient and surgeon once the diagnosis has been made.

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The trauma team concept and its implementation in a district general hospital

We were delighted to read the recent article from Sakellariou *et al.* (*Annals*, January 1995, vol 77, p45). The increasing interest in, and commitment to, trauma and its management by more senior and experienced members of the profession is gratifying and likely to lead to improved survival and reduced morbidity.

More disturbing, however, is the apparent dismissal in a single paragraph of the role of radiography in this team approach and the total disregard of the role of radiology and radiologists in the care of the trauma patient.

Since the establishment of the Helicopter Emergency Medical Service at The Royal London Hospital the active participation of the radiologists has been perceived as an essential part of the trauma team. In addition to the 'on line' interpretation of the radiographs taken as an initial part of the ATLS protocol the presence in the resuscitation room of the radiologist, either a senior registrar or consultant, enables the performance of ultrasound of the abdomen or chest, advice on the appropriateness or otherwise of additional views, the necessity for and immediate arrangement and supervision of CT scanning of the head or body or immediate angiography.

Two further concerns are worthy of note in the paper related to imaging. First is the reliance on portable radiographic machines which, while ideal in the early establishment of the trauma team approach are better substituted by ceiling mounted units which reduce the amount of interference with the on-going patient resuscitation *(1)*.

Secondly, the authors make no mention of their policy in regard to inadequate views of the cervical spine obtained on a single lateral view. Multiple 'pulled' lateral projections and the so-called Swimmers view are all too frequently the first resort of non-radiologically trained observers. In the place of these we would commend the supine trauma oblique views *(2)* which with practice and familiarity are easier to perform and interpret, cause less disruption during on-going resuscitation and assessment and provide exquisite demonstration of the alignment of the anterior, middle and posterior 'columns' of the spine and of the bony facets.

Our comments are intended in no way to diminish the quality of the authors' contribution to the growing realisation of the importance of trauma care and we would congratulate Sakellariou and his colleagues on their commitment to the team approach to trauma care and