

during operative manipulation of the gallbladder before clipping of the cystic duct (three of the four patients had documented dilated cystic duct during LC).

Although operative cholangiography was not performed during the first year of our experience, only two CBD injuries (0.8%) were encountered (one was diathermy related).

We conclude that in the presence of facilities for intravenous cholangiography and endoscopic retrograde cholangiography and adherence to the above selection criteria for preoperative assessment of the CBD before LC safely obviate the need for operative cholangiography and therefore abolish the risk of negative duct exploration.

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Prevention of phantom pain after major lower limb amputation by epidural infusion of diamorphine, clonidine and bupivacaine

It was very encouraging to see an article on the treatment of chronic pain and even better on its prevention (*Annals*, September 1994, vol 76, p324). Since the original imperfect reports by Bach *et al.* in 1988 (1). I have been attempting to convince vascular surgeons of the value of pre-emptive epidural analgesia in minimising post-amputation pain syndromes. However, it does the cause of those patients suffering this extremely disturbing pain no good by overstating the alternatives as in the summary: "There is no effective treatment".

There is no treatment effective in all cases, but there is available a whole range of treatments effective in completely suppressing the pains after amputation, ranging from electrical stimulation applied transcutaneously, to implanted stimulators as well as destructive lesions to the cord and these are recorded in textbooks on the subject (2).

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2 Wall PD, Meltz RR, eds. *Textbook of Pain*, Volume 3. Churchill Livingstone, 1994.

Dislocation after hemiarthroplasty of the hip: a comparison of the dislocation rate after posterior and lateral approaches to the hip

The retrospective review by Unwin and Thomas (*Annals*, September 1994, vol 76, p327) which condemns the posterior approach for hemiarthroplasty, omits important data to support this conclusion. It is not possible to determine whether the type of prosthesis and the technical accuracy of the surgery, influenced the different dislocation rates between the two approaches.

Of the prostheses, 88% were either the Moore or Thompson and of the latter 504 were uncemented. The authors do not give differential rates for each prosthesis, in particular whether the uncemented Thompson, inserted through the posterior approach had an especially high dislocation rate.

It is essential when using the Thompson and Moore prostheses to recognise the differing stem designs, which reflect the use for which each was originally intended. Thompson intended his prosthesis to be used for salvage after non-union/failure of fixation, being designed to sit on the intertrochanteric line (1). Consequently the collar has a steeper angle to restore proximal femoral length. The dagger-shaped stem makes for easy insertion but gives no rotational stability. In consequence, when used in a fresh fracture, with the calcar present, it is often inserted too long, leading to a tight reduction. This tension, combined with an uncemented stem and the retroverting forces on the hip, causes the prosthesis to rotate and dislocate through the deficient posterior capsule.

Moore, however, intended his prosthesis to be used in the fresh fracture if necessary. It was therefore designed to sit on the calcar and he emphasised correct neck cut (2). Furthermore, the fenestrated stem has a shoulder to provide a degree of rotational stability. When inserted correctly through the posterior approach the Moore prosthesis has a minimal rate of dislocation; 0.6% (3); 0 (2); 2.8% (4). The uncemented Thompson inserted through the posterior approach does, however, have a high rate of dislocation (5).

The posterior approach should not be condemned without consideration being given to the type of prosthesis used and the technical adequacy of the surgery. The approach has several advantages, especially in these fracture patients. The abductors are not weakened, an important factor for early postoperative mobilisation in the frail elderly with limited functional reserve. The risk of thromboembolism is also reported to be lower after the posterior approach.

The conclusion from the paper should more accurately be that inexperienced surgeons should not undertake the posterior, or any other approach to the hip. Trainees should remember "a correctly inserted prosthesis seldom dislocates", D'Arcy and Devas (6) on the use of the Thompson prosthesis.

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