

References

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This is an interesting article (*Annals*, July 1997, vol 79, p299) and I agree with the author that it is high time UK guidelines are brought out regarding indications for perioperative blood transfusion. However, the American College of Physicians (ACP) guidelines are for transfusion for transient anaemia from acute blood loss, without considering the surgical implications. Therefore, the 22% 'inappropriate' transfusions in the study for preoperative and persistent postoperative anaemia should not be judged by the ACP criteria. That leaves only 31% inappropriate transfusions, which is not bad considering no guidelines currently exist. The ACP guidelines do not allow for anticipatory transfusions, but one should remember that these may be essential to ensure an optimum outcome, especially in elective surgery. It is standard teaching that anaemia is detrimental to wound healing and integrity of anastomoses. In this respect it would not be wise to operate electively on an anaemic patient (1), especially in the presence of other risk factors like malignancy, jaundice and malnutrition. In this situation it would be unsafe to perform a low anterior resection or a pancreaticojejunostomy, though it may be acceptable to do a total hip replacement.

The anaesthetist is the best person to judge the intraoperative haemodynamic status and should not be restricted by strict guidelines, and Sudhindran reported that adequate reasons for transfusion were not found when examining anaesthetic records. Audet *et al.* (2) have shown the limitations of retrospective medical record reviews in this situation. However, it would have been interesting to know if the staff at Memorial Hospital adhered to any local protocol for blood transfusion. In conclusion, I support the need for a protocol, but this should not be strict ACP guidelines, but a comprehensive and flexible one, catering to each subspecialty (3).

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Randomised trial of subcuticular suture versus metal clips for wound closure after thyroid and parathyroid surgery

We read Selvadurai *et al.*'s paper on closure of the skin after thyroid and parathyroid surgery with interest (*Annals*, July 1997, vol 79, p303).

We would like to recommend a modification of the subcuticular closure technique which reduces discomfort felt by the patient on suture removal. Most of the pain felt during suture removal is due to puckering of the wound as the suture is pulled out, caused by drag between the suture and the wound. Reduction of the length of wound through which the suture is pulled, reduces the amount of puckering and thus reduces pain. We reduce the sutured length to two halves by bringing the suture through the skin surface at approximately the midpoint of the wound and crossing the wound line, as a conventional suture would, before recommencing the subcuticular suture. For removal the suture is divided at its midpoint and removed in two halves from each end. For longer wounds the suture may be exteriorised more than once and removed as a series of short segments.

In our unit, Michel clips are not readily available, disposable skin clip applicators (Auto Suture[®] Royal 35W, £4.35) and extractors (Richard-Allan Disposable Staple Extractor[®], £4.00) being used instead. Therefore in the cost comparison, subcuticular suture closure is the cheaper technique. The use of 3/0 nylon stay sutures by Selvadurai *et al.* to aid accurate clip placement further increases the cost of this technique.

These factors thus favour subcuticular suture closure of wounds after thyroid and parathyroid surgery.

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The Didcott dilator

Mr C C Didcott is correct in his claim regarding the expandable metal dilator (*Annals*, July 1997, vol 79, p307). I first saw and heard him describe it for oesophageal carcinoma at least 25 years ago and I believe that while he may have lost out in the patent registration race, all current hollow viscus expandable metal dilators are based upon or are variations of his original design, whether used in the oesophagus, rectum, arteries, biliary tree or elsewhere. The original concept and design were brilliant and inspired and it is right and proper that Mr Didcott should continue to be recognised by calling these devices Didcott dilators or stents.

Regarding the paper on subcuticular wound closure versus metal clips after thyroid and parathyroid surgery (*Annals*, July 1997, vol 79, p303) Michel clips, by their design and method of application, cause discomfort and pain, and especially so during removal. I do not believe that there is any place in modern surgery for their use.