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## Letters and Comment

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the Notice printed on the inside back cover. Tables and figures should be included only if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and to subedit contributions to ensure clarity

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### Laparoscopic cholecystectomy, bile duct injury and the British and Irish surgeon

We read this paper (*Annals*, March 1998, vol 80, p119) on bile duct injuries with interest. Although we agree with the conclusions of the paper, we do not feel that the data support these.

The group in which selective cholangiography is performed is the only group with enough injuries to draw valid observations, the other numbers being too small to comment on. Within this group we do not know the critical fact of the rate of cholangiography. Clearly, if the rate of cholangiography is 50% then 37/39 is a highly significant number, but if the rate is only 5% then the result would not be significant.

We note that 37 of the 39 injuries from the selective cholangiography group occurred without cholangiogram. There are no data to suggest why no cholangiogram was performed in these patients. In the case of difficult dissections, active inflammation or abnormal anatomy, cholangiography may be difficult and therefore not attempted, and these cases may be at higher risk, both at open and laparoscopic surgery. However, bile duct resection injuries may only have occurred in cases where no cholangiogram was performed because the procedure appeared straightforward.

We would disagree with the authors' statement that, in the event of inadvertent cannulation of the common bile duct, when recognised, "repair is straightforward by introduction of a T-tube". This does not take into account two factors. First, dissection around the common bile duct might have placed the vascular supply of the common bile duct at risk, possibly leading to stricturing. Second, if the incision in the common bile duct (for cannulation) has been extensive, a stricture may ensue. This situation is more likely to occur in a small-calibre common bile duct, which is also more likely to be misidentified at surgery. The ensuing stricturing can be as difficult to treat as the result of a resection injury.

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### An audit of outcome including patient satisfaction with immediate breast reconstruction performed by breast surgeons

I read with interest the article by Berry *et al.* (*Annals*, May 1998, vol 80, p173) reviewing their experience with subpectoral breast reconstruction and I would commend

them on their results, particularly the overall patient satisfaction rates. Although I am an advocate of this type of reconstruction after mastectomy, I think there is an important cautionary point. Despite encouraging patient satisfaction rates in this and other papers, there remains a subgroup of patients for whom this type of reconstruction is inappropriate. When we reported our early results with a different tissue expansion system (1), we found that patients who had substantial breast ptosis, were bad candidates for this type of reconstruction as, even with a period of overexpansion, it was simply not possible to produce the necessary degree of ptosis in the reconstructed breast, and the patient was left with an unpleasant asymmetrical appearance. By contrast, the transverse rectus abdominal myocutaneous flap, although surgically a more demanding procedure, can give excellent cosmetic results in these patients. The converse point is that this type of reconstruction is excellent for patients undergoing reconstruction after bilateral mastectomy for whatever reason.

It is an important responsibility of the breast oncology surgeon to identify unsuitable patients pre-operatively and discuss the reconstructive options and potential problems openly and, if necessary, make a suitable tertiary referral. I would imagine that most patients would opt, out of personal preference, for an immediate reconstruction with a tissue expander rather than a second major reconstructive operation at a later stage, which for certain patients would be an unwise decision for the long term. Although the results presented in this paper are good, suggesting that patients were appropriately selected, it is perhaps important to make this point overtly, particularly as more and more general surgical units begin to offer this type of immediate reconstruction.

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#### Reference

- 1 Hayes AJ, Jenkins M, Sandhu S, Baum M. Subpectoral breast reconstruction using the bidimensional system. *Ann R Coll Surg Engl* 1997; 79: 355-60.

#### Author's reply

I am very grateful to Mr Hayes for his comments regarding the limitations of use of the subpectoral expander prosthesis form of immediate breast reconstruction.

We also have reservations regarding the use of this form of reconstruction with very ptotic breasts, unless contralateral surgery to correct ptosis is contemplated.