

Surgical treatment of ingrown toenails in children

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COMMENT ON

Mitchell S, Jackson CR, Wilson-Storey D. Surgical treatment of ingrown toenails in children: what is best practice? *Ann R Coll Surg Engl* 2011; **93**: 99–102
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Your paper highlights the significant morbidity associated with ingrown toenails in the paediatric population and the difficulties in treatment. We agree that wedge excision alone does not constitute adequate initial management. However, there are risks associated with the use of phenol, including soft tissue burns and increased infection rates. We routinely perform wedge excision with bipolar diathermy ablation of the nail bed with excellent results. In our series of 302 children over a 7-year period, only 30 patients (9.9%) suffered a recurrence that required reoperation.¹ No other significant complications were observed and 97.2% of parents/children reported being 'satisfied' or 'very satisfied' with the procedure. We believe that our technique combines the advantages of speed, simplicity and minimal bleeding with low morbidity, minimal discomfort and high levels of patient satisfaction.

Reference

1. Farrelly PJ, Minford J, Jones MO. Simple operative management of ingrown toenail using bipolar diathermy. *Eur J Pediatr Surg* 2009; **19**: 304–306.

Minimising perioperative homologous blood transfusions

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COMMENT ON

Ubee S, Kumar M, Athmanathan N, Singh G, Vesey S. Intraoperative red blood cell salvage and autologous transfusion during open radical retropubic prostatectomy: a cost–benefit analysis. *Ann R Coll Surg Engl* 2011; **93**: 157–161
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We read with interest the work of Ubee *et al* and commend the authors for addressing the important issue of minimising perioperative homologous blood transfusions. We have used cell salvage in our department for all major urology cases and have regularly audited our results since 1996.¹ We agree with the authors' conclusions that cell salvage is safe and cost effective. Furthermore, we feel that several important points should be emphasised.

Firstly, in addition to acknowledged transfusion risks, homologous blood products are a precious diminishing resource. All methods to conserve blood should be actively employed. Knowledge and implementation of the threshold transfusion level of 7g/dl is essential in asymptomatic patients without comorbidity.

Secondly, although there is evidence to support the statement that the use of cell salvage does not affect oncological outcome, it is impossible to deduce this from the current series owing to the fact that the time period and the duration of follow-up is not documented. Similarly, the reason for the shorter hospital stay is likely to be multifactorial in this consecutive series rather than due to cell salvage alone.

Thirdly, with improved anatomical knowledge and the minimally invasive techniques of laparoscopic and robotic surgery becoming more prevalent, blood loss during radical prostatectomy has decreased considerably.² Although the ultimate surgical goal may be bloodless intervention, we are not there yet. The advantage of cell salvage is that there is a 'suck and save' option, where not all the consumables need to be opened unless a significant level of blood is lost intraoperatively. In our centre the cost of this is £25, thereby making cell salvage both cost-effective and a vital adjunct in major urology cases. Our current mean blood loss at open radical retropubic prostatectomy is 325ml and we find that cell salvage is still financially viable, even setting aside other benefits.

References

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2. British Association of Urological Surgeons. *BAUS Cancer Registry: Analyses of Complex Operations, 1st January – 31st December 2009*. London: BAUS; 2010.