

References

1. Shenfine J, Hayes N, Richardson DL, Griffin SM. Combined percutaneous-endoscopic management of a perforated esophagus: a novel technique. *Gastrointest Endosc* 2001; **54**: 649–651.
2. Griffin SM, Lamb PJ, Shenfine J *et al*. Spontaneous rupture of the oesophagus. *Br J Surg* 2008; **95**: 1,115–1,120.
3. D'Cunha J, Rueth NM, Groth SS *et al*. Esophageal stents for anastomotic leaks and perforations. *J Thorac Cardiovasc Surg* 2011; **142**: 39–46.

AUTHORS' RESPONSE

JH Darrien, H Kasem

NHS Lanarkshire, UK

doi 10.1308/003588414X13814021678718

CORRESPONDENCE TO

Jennifer Darrien, E: jenniferdarrien@hotmail.com

Thank you for your comments on this article and the issues that you raise. At the time of managing these patients, we were limited to using the stents that we had available to us in our unit (Ultraflex™; Boston Scientific, Natick, MA, US). When we realised they were not providing an adequate seal, we looked for alternatives and changed to the Polyflex® stent (Boston Scientific). These provided a greater radial force than that of the Ultraflex™ stents, and they were more effective in both excluding the defect from the alimentary tract and preventing the development of further associated mediastinal and pleural collections. Once we were aware that the Polyflex® stent was superior to the Ultraflex™ stent, it was subsequently used as a primary treatment modality without complication.

We are sorry for not citing your unit's paper describing a similar rendezvous type technique to that of our own. I am sure that we would have benefitted from your expertise. We would, however, like to draw your attention to the extensive bariatric literature now available supporting the use of stents in the management of oesophagogastric leaks and perforations.^{1–3} These demonstrate both the safety and efficacy of plastic covered self-expandable metallic stents in managing challenging clinical circumstances.

While we agree that the mainstay of treatment for this condition should be surgical, we are more pragmatic in our approach and recognise that in selected patients who perhaps present late with established multiorgan dysfunction or have significant co-morbidity, a dogmatic approach may be somewhat risky. As such, we put forward our technique for consideration in selected circumstances where surgery may be ill advised.

References

1. Blackmon SH, Santora R, Schwarz P *et al*. Utility of removable esophageal covered self-expanding metal stents for leak and fistula management. *Ann Thorac Surg* 2010; **89**: 931–936.
2. Spyropoulos C, Argentou MI, Petsas T *et al*. Management of gastrointestinal leaks after surgery for clinically severe obesity. *Surg Obes Relat Dis* 2012; **8**: 609–615.
3. Simon F, Siciliano I, Gillet A *et al*. Gastric leak after laparoscopic sleeve gastrectomy: early covered self-expandable stent reduces healing time. *Obes Surg* 201; **23**: 687–692.

Twist-over: stainless steel suture technique for skin graft applications

CR Macdonald, PE Banwell

Queen Victoria Hospital NHS Foundation Trust, UK

doi 10.1308/003588414X13814021679276

CORRESPONDENCE TO

Chris Macdonald, E: cmacdee@hotmail.com

COMMENT ON

Shokrollahi K, Sofos S.

Twist-over: stainless steel suture technique for skin graft applications.

Ann R Coll Surg Engl 2013; **95**: 437

doi 10.1308/003588413X13629960048875a

Shokrollahi and Sofos' article is excellent but fails to reference the 'herniotomy approach' published by Choudhary and Lam in 1999,¹ a technique to which theirs bears some core similarities. Choudhary and Lam describe using a silk suture to secure the graft at its periphery, leaving the suture ends long. These suture ends are then drawn together and twisted until they apply sufficient force on the underlying bolster (as repeated in Shokrollahi and Sofos' technique). A single stitch tied around the twisted bundle of threads secures it. Some years ago, we modified this technique such that the final stitch weaves over and under each of the tie-over strands just before they become entwined to stop any slippage.

Although our final suture may add an additional few seconds of operative time compared with the stainless steel 'twist-over' technique, we feel that this is more than compensated for by the use of a significantly cheaper stitch material that can be removed quickly and easily with the use of any blade or stitch cutter.

Reference

1. Choudhary S, Lam DG. Simple tie-over: the herniotomy approach. *Plast Reconstr Surg* 1999; **104**: 1,573–1,574.

Streptococcal toxic shock syndrome following total thyroidectomy

J Forsythe

NHS Lothian, UK

doi 10.1308/003588414X13814021679555

CORRESPONDENCE TO

John Forsythe, E: john.forsythe@nhslothian.scot.nhs.uk

COMMENT ON

Hung JA, Rajeev P.

Streptococcal toxic shock syndrome following total thyroidectomy.

Ann R Coll Surg Engl 2013; **95**: 457–460

doi 10.1308/003588413X13629960048118

We were interested to read this review. In fact, we described this rare but potentially fatal complication following a

thyroidectomy some years ago.¹ We had experienced a severe and fatal case, and when we heard of a similar patient in a neighbouring unit, we were prompted to undertake an investigation including many of the UK endocrine surgeons.

It became clear that a rapid development of septic shock following proven or putative streptococcal infection was a very rare but real complication after thyroidectomy. Since some patients had been operated on for benign thyroid conditions, the rapid deterioration of the individual patient was described as very frightening, even with appropriate escalation of care. One surgeon described how it almost put him off further operating as his young patient succumbed to infection.

Our paper also discussed the possible source of sepsis, whether it was environmental or from the patient involved.

We would be grateful if this paper, published in 2007, could be noted as a contradiction to the first line of your review article.

Reference

1. Hardy RG, Forsythe JL. Uncovering a rare but critical complication following thyroid surgery: an audit across the UK and Ireland. *Thyroid* 2007; **17**: 63–65.

A secure retraction technique for exposing the internal mammary vessels

AN Morrith, SH Wood

Imperial College Healthcare NHS Trust, UK
doi 10.1308/003588414X13814021679636

CORRESPONDENCE TO

Andrew Morrith, E: andrewmorrith@hotmail.com

COMMENT ON

Taghizadeh R, Stevenson S, Williams N.

A secure retraction technique for exposing the internal mammary vessels. *Ann R Coll Surg Engl* 2013; **95**: 533
doi 10.1308/003588413X13781990150491h

Taghizadeh *et al* report a retraction technique for exposure of the internal mammary vessels during autologous microsurgical breast reconstruction. We have used an

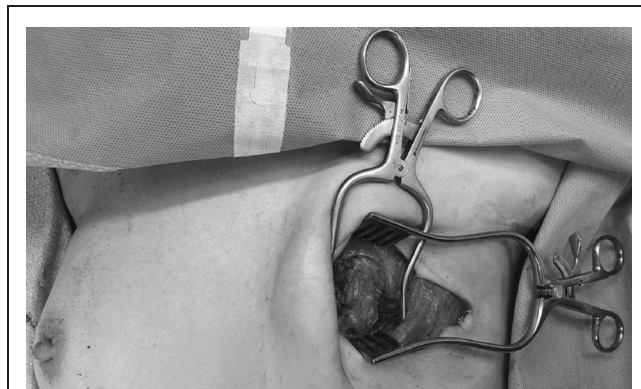


Figure 1 Two self-retaining retractors positioned at right angles

alternative approach successfully for many years. This involves positioning a West self-retaining retractor so that one jaw is under the cut end of the rib while the other retracts the mastectomy flap. Another self-retaining retractor (either a West or a Travers retractor) is positioned at a right angle to the first self-retainer (Fig 1) to retract the pectoralis major muscle and mastectomy flaps. Our technique is simple to perform, provides adequate exposure, is intrinsically stable and obviates the need for a stabilising ribbon, which could potentially provide an obstacle for the assistant.