
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 subedit contributions to ensure clarity

Improving exposure and safety at the saphenofemoral junction

I read with interest the article by Messrs Wakefield and Elewa (*Annals*, March 1995, vol 77, p139) and the letter by Mr Edwards (*Annals*, September 1995, vol 77, p395). I too was trained to use a similar technique for safe exposure of this area. Once the long saphenous vein is identified I pick it up with a small artery forceps and use this as a retractor while dissecting the tributaries and junction with predominantly blunt dissection with a pair of non-toothed forceps. Having safely identified the junction before any vessels are divided, I then use Ligaclips on the distal part of the tributaries and ligate the junction. The tributaries are then divided and the long saphenous vein stripped. I believe the resulting 'mushroom' of the divided proximal parts of the tributaries which is situated just distal to the ligature on the junction may help to prevent the ligature from slipping off the divided long saphenous vein.

I believe this technique to be rapid and safe, and in my experience the use of Ligaclips speeds the procedure further and has not resulted in any greater incidence of haemorrhage postoperatively. I would, however, caution against the use of an artery forceps as a retractor on a saphena varix.

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Can preoperative factors predict for residual malignancy after breast biopsy for invasive cancer?

I found the above-titled paper (*Annals*, July 1995, vol 77, p248) puzzling. In the USA the excised specimen is immediately sent for a 'frozen section' report to confirm that the malignant lump has been completely removed with adequate margins of healthy tissue. If tumour is found at any one of the resected lines the surgeon then immediately removes more tissue which is then similarly evaluated. Although this may prolong the operation to some extent, both patient and surgeon can leave the operating theatre with the reassurance that the operation is technically complete.

I would value comments by the authors on this approach which, according to their study, is not practised in their institution.

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Authors' reply

We thank Dr Singer for his comments. In Britain we have long realised that frozen section is an inexact method for assessing the margins of healthy tissue and, in particular, it is a poor way of assessing the presence or absence of *in*

situ carcinoma in the breast. We prefer to wait for formal paraffin sections to make assessment about resection margins.

The question of operating time is very pertinent; frozen sections take at least half an hour to perform and many of the cancers were diagnosed by biopsies carried out in patients using needle localisation techniques. These specimens need to be radiographed to confirm removal of the suspicious lesion, which takes approximately 15 min, so that the addition of a frozen section would add 45 min to every operation. Many of these patients having diagnostic biopsies would have had inappropriate frozen section sampling; we have not reported on the benign localisation biopsies which were sampled because of mammographic abnormalities which subsequently turned out to be benign. Dr Singer may not routinely participate in a Breast Screening Programme and may not have experienced the difficulties with frozen section in assessing borderline lesions in the breast.

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Laparoscopic appendicectomy: a trainee's perspective

Although we agree with the suggestion by Botha *et al.* (*Annals*, July 1995, vol 77, p259) that basic laparoscopic training should be introduced early in surgical training, we entirely disagree with their recommendation that laparoscopic appendicectomy should be the training operation of choice for junior surgeons. In our department, training of junior surgical residents in laparoscopy takes place very early in their training using laparoscopic cholecystectomy as the training operation, starting as cameramen and later by allowing them to introduce pneumoperitoneum and insert various trocars. At a later stage, they are allowed to dissect the gallbladder off its hepatic bed after clipping and division of the cystic duct and artery by an experienced laparoscopic surgeon. The dissection at Calot's triangle is only allowed at a very late stage in their training to avoid common bile duct injury. This gradual introduction of junior surgeons has proved to be safe and effective since laparoscopic surgery was launched at our department in June 1992.

In our opinion laparoscopic appendicectomy is not the operation of choice for training junior surgeons. Firstly, appendicectomy is the commonest emergency operation performed by junior surgeons in training as the principal operators, giving them the first flavour of basic operative techniques in open surgery, which will be denied if the procedure is carried out laparoscopically, necessitating the

presence of a senior surgeon. Secondly, the majority of appendicectomies are performed out of hours, especially at night, and the need for the presence of a senior surgeon at these times has practical implications (1).

Furthermore, in our opinion, as the benefits from laparoscopic appendicectomy are less pronounced than for laparoscopic cholecystectomy, it should be reserved for patients undergoing diagnostic laparoscopy for right iliac fossa pain, especially in young female patients.

Therefore, we believe that laparoscopic cholecystectomy and not laparoscopic appendicectomy should be the training operation of choice for junior surgeons.

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Clinical studies of human islet transplantation

Although an experimental procedure, the intraportal transplantation of purified allogenic islets has proved to be a safe and sometimes efficient technique in immunosuppressed type 1 diabetic patients. We read with much interest the recent paper by N J M London (*Annals*, July 1995, vol 77, p263) describing the islet allotransplantation experience at Leicester, including one patient displaying long-term c-peptide secretion but no insulin withdrawal after transplantation of islets from one donor matched for 2/2 DR loci and 2/4 AB loci. However, we disagree with the author's assertion that clinical islet transplantation studies should be pursued exclusively with islets from a single, well major histocompatibility complex (MHC) matched donor.

Most diabetic patients who eventually become normoglycaemic after islet transplantation were grafted with islets obtained from multiple and poorly MHC matched donors. A patient was also successfully transplanted with purified islets from only one pancreas, from a donor sharing no antigen with the recipient in the DR and AB loci (1). The review of the results of 36 islet transplantations from single donors does not show any correlation between MHC matching and function of transplanted islets after 1 month or 1 year (2). Although the author quoted some experimental data suggesting the detrimental effect of transplantation of islets from more than one donor, he failed to report other studies reviewed recently (3) demonstrating a positive effect of multiple donors on the outcome of islet transplantation in rodents. Even in established organ transplantation procedure, the importance of the MHC matching remains controversial. A recent comprehensive report comparing the results of renal transplantation from non-related living donors with

transplantation from MHC matched cadaveric donors convincingly demonstrates that the influence of quality of the graft surpasses that of MHC matching (4). For islet transplantation the quality of the graft may be assessed by quantity, viability and function of the isolated islets. It is noteworthy that long-term c-peptide secretion in one patient in London's report correlated also with the best function of grafted islets according to the *in vitro* testing performed.

To date, no conclusive evidence supports the restrictive use of MHC matched donors in clinical islet transplantation. Therefore, in light of the low number of pancreata harvested for pancreas transplantation (less than 10% of available organs) and the lack of significant improvement in islet isolation technique, we are impelled to consider transplantation of islets from multiple donors for clinical application in diabetic patients with the best chance of cure.

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Split loop colostomy: a modification

Mr Kelly's adaptation (*Annals*, July 1995, vol 77, p313) recently proved of great value and we should like to thank him for bringing this modification to press. A 58-year-old lady underwent a palliative right hemicolectomy and subsequently adjuvant chemotherapy for residual pelvic peritoneal disease. Unfortunately, 9 months later she developed a malignant rectovaginal fistula. As the pelvis was frozen, a 'trephine' approach was used to fashion a defunctioning stoma. The faeculant discharge cleared within 2 days as the above modification allowed the distal limb of the split loop to be irrigated until a clear effluent was obtained. If this ingenious modification had not been published in the *Annals* the lady's distressing symptoms would no doubt have taken much longer to subside.

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