

predictor of outcome rather than a determining factor in selection of the type of therapy. If an anterior external anal sphincter defect is noted, the patient with sphincter atrophy would undoubtedly still undergo an overlapping repair. The atrophy might be used to predict outcome rather than to direct the type of therapy. We certainly hope that Briel *et al.* are correct as the more prognostic information we have preoperatively, the better we can inform patients of realistic expectations.

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- 1 Wexner SD, Marchetti F, Jagelman DG. The role of sphincteroplasty for fecal incontinence reevaluated: a prospective physiologic and functional review. *Dis Colon Rectum* 1991; **34**: 22-30.
- 2 Oliveira L, Pfeifer J, Wexner SD. Physiological and clinical outcome of anterior sphincteroplasty. *Br J Surg* 1996; **83**: 502-5.

Causes of re-recurrence after polytetrafluoroethylene patch saphenoplasty for recurrent varicose veins (*Br J Surg* 2000; **87**: 1356-60)

Sir

One possible explanation for the claimed advantage of polytetrafluoroethylene patching is the more extensive dissection of the saphenofemoral junction that is required in this procedure. This may lead to a more complete ligation of all the tributaries in this region. Maybe the answer lies in ensuring complete technical success at initial surgery. On-table Doppler studies may provide the answer. Like the authors we agree that more prospective randomized trials are required to determine which surgical technique offers the lowest recurrence rate, if any at all.

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Effect of colectomy on gastric emptying in idiopathic slow-transit constipation (*Br J Surg* 2000; **87**: 1193-6)

Sir

I am surprised that this paper was submitted for publication without presenting a prospectively collected, age and sex-matched, control group for comparison. The authors state that

the normal range for gastric emptying taken from volunteer studies is 20-76 min. A prospective study from the same department¹, however, showed that the mean(s.d.) gastric emptying time ($t_{1,2}$) in unselected women of similar age was 89(22) min. Most of these controls had an emptying time greater than that which was stated to be the upper limit of normal. This error is understandable when an author tries to harvest some of the data retrospectively. Some of the patients in the present study therefore probably have normal gastric emptying, a fact that has been identified previously¹. The current publication could be misleading and this might have been avoided if previously published work from the same department had been read thoroughly before being referred to¹.

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- 1 Macdonald A, Baxter JN, Bessent RG, Gray HW, Finlay IG. Gastric emptying in patients with constipation following childbirth and due to idiopathic slow transit. *Br J Surg* 1997; **84**: 1141-3.

Authors' reply

Sir

While we were aware of Mr Macdonald's publication (our reference 11), we chose to use the normal range accepted by the Department of Nuclear Medicine at Glasgow Royal Infirmary. When corrected for decay of the radionuclide the normal range for gastric emptying is 20-100 min. This corresponds to 20-76 min for uncorrected counts: Mr Macdonald clearly failed to read our text where our use of uncorrected counts is clearly detailed (paragraph four of Patients and Methods). We were surprised at Mr Macdonald's suggestions regarding controls. His entirely female control population would not represent our population of men and women. This, in addition to our use of uncorrected counts, explains the difference between his control group and our quoted normal range. Finally, we doubt whether we would be able to find, as he suggests, an age and sex-matched normal population prepared to undergo colectomy as controls for this study.

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