



# Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. Tables and figures should only be included if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and subedit contributions to ensure clarity.

## COMMENT ON

**NK Chandha, S Cumming, R O'Connor, M Burke.** Is discharge with drains after breast surgery producing satisfactory outcomes? *Ann R Coll Surg Engl* 2004; **86**: 353–7

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## A Caribbean perspective

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I read, with great interest, the documented advantages and cost-effectiveness of early discharge following breast surgery. In our Caribbean setting, bed shortages and cost implications have forced us to look into early discharge for these patients. In 203 consecutive patients under going axillary clearance with either mastectomy or segmentectomy, the mean hospitalisation was 22 h (including 18 h postoperative stay). Because we have neither district nor hospital-based nursing care at home, a responsible relative (and/or the patient herself) is taught to empty and reseal the suction drain. All patients are afforded telephone contact with our surgical office. We have had 2 cases where the drain inadvertently dropped out at home – one on the 2nd and the other on the 7th postoperative day. The former required repeated aspiration as an out-patient; no patient needed re-admission. In another 2 cases, patients experienced leakage around the drain site; this only necessitated a change of dressing. In my view, not only is early discharge possible but there is little gain in keeping the patient beyond 24 h. Moreover, one can further reduce cost of

home care by teaching the patient or a responsible relative how to manage the drain.

## COMMENT ON

**DR Cameron, AJ Goodman.** Delayed cholecystectomy for gallstone pancreatitis: re-admissions and outcomes. *Ann R Coll Surg Engl* 2004; **86**: 358–62

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## Management of gall stone pancreatitis

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The excellent study by Cameron and Goodman demonstrates the various problems associated with management of gall stone pancreatitis, particularly as a result of a delay in performing cholecystectomy. One of the important aspects of management of such cases is when and how to assess the common bile duct and whether it needs to be assessed in all patients. It has been mentioned by the authors that policies varied according to the surgeons but without clarification of these policies.

The four patients who developed recurrent pancreatitis in this study, prior to laparoscopic cholecystectomy were those who had either a normal MR cholangiogram or were waiting for pre-operative cholangiography. One fatality occurred as a result of endoscopic retrograde cholangiopancreatography (ERCP)-induced pancreatitis. It is important, therefore, that there should be clear indications for common bile duct assessment prior to proceeding with cholecystectomy, as a delay in obtaining an ERCP or MR cholangiogram and, at times, ERCP itself may lead to complications.

A number of studies have shown that the incidence of common bile duct stones is negligible following an attack of pancreatitis if the liver function tests have returned to normal and the ultrasound does not show a dilated common bile duct. A case can, therefore, be made for proceeding directly with

cholecystectomy in such cases at the index admission once the patients have settled clinically, without any form of common bile duct assessment.

### Bibliography

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3. United Kingdom guidelines for the management of acute pancreatitis. *Gut* 1998; **42** (Suppl. 2): S1–13.
4. Sinha A, Arnaut F, Fisher N. Do all patients with recent acute gallstone pancreatitis need CBD treatment? *J Gastrointest Surg* 2004; **8**: 377A–8A.

### AUTHOR'S RESPONSE

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We agree that, in the majority of cases, pre-operative cholangiography will be negative and, therefore, causes unnecessary delay, expense and potential morbidity. An intra-operative cholangiogram means that most patients will have only one procedure and the absence of persisting common bile duct stones can be documented. If choledocholithiasis is found, the options depend on the surgical, laparoscopic and endoscopic resources and skills available.

### COMMENT ON

**DJ Bowrey, MI Otter, PJ Billings.** Rectal infiltration by prostatic adenocarcinoma: a report on six patients and review of the literature. *Ann R Coll Surg Engl* 2003; **85**: 382–5

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### Transanal resection of the prostate

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We note that the majority of surgically treated patients in this review ended up with a colostomy. Most patients are

elderly with a limited life expectancy and a defunctioning colostomy may be difficult to manage. An alternative palliative option is transanal resection of the prostate,<sup>1</sup> which was not mentioned in the paper. This is a simple, well-tolerated, minimally invasive procedure, which may prevent the need for a laparotomy or stoma, with resultant satisfactory palliation of obstructive symptoms for the remainder of the patient's life.

### Reference

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### COMMENT ON

**E Benjamin, G Alusi.** A head and neck cancer database for the 21st century. *Ann R Coll Surg Engl* 2004; **86**: 404–6

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### Computerised databases

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The use of computerised databases in head and neck cancer surgery reported by Benjamin and Alusi is welcome; however, this concept is not restricted to the 21st century! Rogers *et al.*<sup>1</sup> published a similar idea in this journal in 1993, which has been in place and in regular use in several units since this date. In the Aintree Maxillofacial Unit, the data generated by this resource (about 1600 malignancies entered) have proved invaluable – as illustrated by some 17 research papers generated within the last 2 years or so that have been facilitated by the database.

No doubt the more convenient use of hand-held computers affords some logistical advantages; however, the propensity of even large (and occasionally bolted down) hardware to 'walk' out of the hospital has been noted in North Liverpool. Whilst the cost of replacement hardware may be simple to offset, issues related to patient confidentiality, consent and security of data are clearly of increasing importance.

Finally, it is interesting to note the authors' use of the historical term 'Commando' procedure in Figure 5, presumably signifying the combined resection of mandible and oral/oro-pharyngeal soft tissues. The term appears to originate at Memorial Hospital in New York during the early part of the Second World War, when daring commando raids were often reported in the news. A similar daring attitude was no doubt required to perform such a destructive operation,

particularly as no acceptable reconstruction was available until the introduction of composite-free tissue transfer using microvascular techniques during the 1980s. This operation was carried out in the belief that in any oral tumour, the lymphatics drained through the mandibular periosteum and bone and then to the neck,<sup>2</sup> a concept since discredited.<sup>5</sup> In modern practice, it is often unnecessary to perform segmental mandibular resection, even when the jaw is frankly invaded, and a more conservative approach can be applied with good marginal control<sup>4-7</sup> and corresponding survival rates.<sup>8</sup>

Perhaps the term 'Commando', and all it implies, has had its day in the enlightened head and neck oncology practice of the 21st century, in which we now have the benefit of evidence gained from computerised databases?

## References

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## AUTHORS' RESPONSE

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We welcome Mr Shaw's comments on our database, and the agreement as to the importance of computerised databases in cancer surgery. Obviously, the historical point regarding

the term 'Commando procedure' is of interest but beyond the subject matter of our article.

The point of our paper, however, seems to have been missed. Where our database differs from its historical predecessors is the whole concept of its portability. This allows more accurate, prospective, data collection especially of outcomes and complications rather than prospectively entering data on to an office-restricted PC. It also provides a database that can be used at the point of source, *i.e.* directly for on-going patient management (a criteria suggested by the Data Protection Act). Theodor Bilroth used a quill and parchment to write his operation note on the first laryngectomy in 1873 and Victor Negus in the 1920s would have documented his endoscopic findings with conventional pen and paper. Mark Singer and Eric Blom no doubt used a desktop PC for collecting their data on tracheo-oesophageal valves. As advances continue in all aspects of head and neck surgery, then data collection methods will also advance. In the 21st century, surgeons need to have data available at their fingertips – or at least in the palm of their hands!

## COMMENT ON

**A Jah, R Mulla, FD Lawrence, M Pittam, D Ravichandran.** Tuberculosis of the breast: experience of a UK-based clinic serving an ethnically diverse population. *Ann R Coll Surg Engl* 2004; **86**: 416-9.

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## Extrapulmonary tuberculosis

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In countries where tuberculosis is a significant problem, the incidence will obviously be higher and the degree of clinical suspicion greater. In my unit, in the past month, we have seen three cases. Extrapulmonary tuberculosis can occur virtually anywhere in the body; however, its association with HIV disease must not be forgotten. Where HIV is endemic, this association will be common; in our environment, it is extremely rare to find a case of extrapulmonary tuberculosis who is not HIV positive. The CD4 counts are usually, but not always, less than 200, and antiretroviral therapy is indicated, usually after tuberculosis therapy is completed.

**COMMENT ON**

**MG Smith, P Dunkow, DM Lang.** Treatment of osteoporosis: missed opportunities in the hospital fracture clinic. *Ann R Coll Surg Engl* 2004; **86**: 344–6

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**Fracture Liaison Service**

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This article addresses the important issue of identifying patients with osteoporosis. It concludes that 'current' mechanisms for identifying patients with osteoporosis before they sustain a femoral neck fracture are inadequate. The findings confirm those of other studies that uptake of investigations is less than 10% when referral relies on orthopaedic surgeons or primary care physicians.

We are fortunate, in Glasgow, that a successful Fracture Liaison Service was established about 4 years ago under direction of the Bone Metabolism Clinic. All patents over the age of 50 years presenting with low energy fractures are evaluated by osteoporosis specialist nurses. Bone mineral density testing is offered according to agreed criteria. Treatment recommendations are made to the patients' general practitioners.

During the first 18 months of the service, 4600 fracture patients were assessed.<sup>1</sup> Nearly three-quarters were offered bone mineral density testing and 82.3% of these were found to be osteoporotic.

We understand that a number of other Fracture Liaison Services in the UK and abroad have been established modelled on the Glasgow service.

**Reference**

1. McLellan AR, Gallacher SJ, Fraser M, McQuillan C. The fracture liaison service: success of a program for the evaluation and management of patients with osteoporotic fracture. *Osteoporosis Int* 2003; **14**: 1028–34.

**AUTHORS' RESPONSE**

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We were delighted at these very useful comments regarding the mechanisms for identifying patients with osteoporosis. It is gratifying to see that other centres are working toward the common goal. Obviously, the service developed in Glasgow has many merits; however, there are currently few centres in the UK that have the necessary resources to accommodate osteoporosis specialist nurses. Consequently, this results in the issues being overlooked.

We have developed a high-tech, low-cost computerised system that automatically identifies patients with osteoporosis and refers them to the appropriate clinician for appropriate management. The advantages are that minimal resources are required to set this up with virtually no on-going costs being incurred and that it will merge conveniently with the *New NHS IT Plan*.

We aim to report on our experiences in the near future and, like the Glasgow model, we envisage interest from other centres who wish to address these important issues, especially those with limited resources.

**COMMENT ON**

**MJA Turner, AD Purushotham.** Accidental EpiPen injection into a digit – the value of a Google search. *Ann R Coll Surg Engl* 2004; **86**: 218–9

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**Google versus PubMed**

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We suggest that while Google can be a useful tool in finding clinical information quickly, as the authors' anecdotal evidence

shows, PubMed should remain the database of choice for the reasons argued below.

Turner and Purushotham's search strategy makes no use of the PubMed controlled vocabulary (Medical Subject Headings), and their failure to find relevant information can be attributed to this lapse, not to a defect in the PubMed database itself.

A search using the terms 'Accidents' and 'Epinephrine' results in 10 relevant hits. Both terms are represented in the Medical Subject Headings that are freely available to all using PubMed.

Even a naive text word search similar to one employed by the authors will return valuable and relevant citations in PubMed. For example, a search consisting of the terms 'accidental' AND 'epipen' AND 'injection' returns two relevant citations.

A search consisting of the terms 'epinephrine' AND 'injection' AND 'hand' limited to 'All Child: 0–18 years' returns 15 citations, of which five are directly related to the problem.

In performing their original PubMed search, Turner and Purushotham made another error common to inexperienced searchers. They used too many search terms. Generally speaking, any time more than three terms are used in searching, the chance of retrieving zero citations increases greatly. Note that none of the search examples in this letter use more than three terms. Contrast the simplicity of our example searches with the complexity of the search in the original article.

Furthermore, the article that the authors located via a Google search would not have been retrieved under any circumstances using PubMed because the journal in which it was published is not indexed by PubMed.

It should be obvious from the examples above that this article, far from demonstrating the superiority of Google in locating clinical information, illustrates instead the value of clinical staff being properly trained in the use of PubMed and other clinical databases. We recognise that busy surgeons might not have the time to maintain skills necessary to retrieve relevant citations and articles whilst in the midst of emergency situations, so we also suggest that clinicians keep the phone number of their nearest medical librarian close at hand.

## COMMENT ON

**DA Ashdown, D Bodiwala, S Liu.** Is high cord radical orchidectomy always necessary for testicular cancer? *Ann R Coll Surg Engl* 2004; **86**: 289–91

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## Inguinal orchidectomy

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We were interested to read this paper describing an unrandomised series of high and low cord inguinal orchidectomies in the treatment of testicular neoplasms in Stoke. Unfortunately, both the concept and the content of this paper are questionable.

The authors' thesis suggests that low cord radical orchidectomy would prove advantageous in terms of a reduction in complication rate in comparison with standard radical orchidectomy (high cord). The authors suggest that cancer control would not be compromised.

There is, however, no literature to our knowledge that suggests a lower complication rate for low cord orchidectomy nor do these authors compare the two.

The authors describe no statistically different rate of relapse between the two groups, but do not disclose how they define relapse (usually presented in terms of either clinical, radiological or biochemical relapse). It is, therefore, not possible to conclude anything about comparative relapse rates in this non-randomised series.

There are two theoretical, but significant, disadvantages to leaving the cord behind at the time of inguinal orchidectomy. The first is that it is possible to identify tumour cells within the spermatic cord of 5% of men undergoing inguinal orchidectomy (personal communication from Mr T Christmas, Royal Marsden Hospital). There is, therefore, a theoretical risk of leaving cord disease behind.

The second disadvantage is that at the time of subsequent retroperitoneal lymph node dissection, if this proves necessary, it is much harder to clear the remaining cord structures from above without further exploration of the inguinal canal.

Our suggestion is that standard (high cord) inguinal orchidectomy should be undertaken for the treatment of men with testicular tumours and this paper does not elucidate any new data suggesting to the contrary.