The Royal College of Surgeons of England

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