Overall, in our study, if the patient had not undergone any previous treatment for malignancy prior to presentation with malignant ureteric obstruction and, therefore, the prospect for future disease-related treatment existed, the median survival was 137 days. This fell dramatically to 76 days if the presentation with malignant ureteric obstruction was due to disease progression, with the patient already having undergone disease-specific treatment. This figure falls further to 60 days if the two patients with unaccountably long post-nephrostomy insertion survivals (711 and 814 days) are excluded. These figures are indeed longer than those proposed by Watkinson *et al.*² If, however, our data are stratified in a similar fashion to Watkinson *et al.*² our median survival is equally poor for patients with relapsed disease who received palliative treatment only following nephrostomy insertion (median survival, 42 days). These data were not included in our original paper and we apologise for any confusion that this omission may have caused. We would whole-heartedly support the statement by Drs Lane and Hines that the management of such patients needs to be individualised and discussed in front of a multidisciplinary team, before being able to offer the patient and his/her family balanced information to enable an informed decision on the merits of intervention.

We would also like to take this opportunity to thank Dr NG Warnock and Dr A Bowker, Consultant Radiologists at York Hospital, for their invaluable work in undertaking all of the percutaneous nephrostomy and antegrade ureteric stent placements in our paper. Again, we offer our apologies for their omission in the original paper.

References

1. Chitale SV, Scott-Barrett S, Ho ETS, Burgess NA. The management of ureteric obstruction secondary to malignant pelvic disease. *Clin Radiol* 2002; **57**: 1118–21.
2. Watkinson AF, A'Hern RP, Jones A, King DM, Moskovic EC. The role of percutaneous nephrostomy in malignant urinary obstruction. *Clin Radiol* 1993; **47**: 32–5.

COMMENT ON

A Bourne, M Rhodes. Control oozing during laparoscopy with a swab. *Ann R Coll Surg Engl* 2005; **87**: 389

doi 10.1308/003588406X106414

Alternative swabs

MA SCOTT, G ATKIN, RJ FOLEY

Department of Surgery, Bedford Hospital, Bedford, UK

CORRESPONDENCE TO

Mr MA Scott, Department of Surgery, Bedford Hospital, Bedford MK42 0DJ, UK. E: mikescott@doctors.org.uk

We read this Technical Tip with interest and very much agree that utilising a swab can be invaluable in maintaining

optimum views during a number of laparoscopic procedures. The authors report using a 3 x 4 inch swab to apply pressure to an area of oozing. This requires the removal of the laparoscopic port to extract the swab. We would suggest the use of a tonsil swab (6 x 1 inches) which has the advantage of easily being introduced and removed through a 10-mm port without the necessity of removing the port itself.

An intraperitoneal swab can also be used to great effect in conjunction with a suction irrigation system. Placing the tip of the irrigation catheter into the swab enables fluid to be instilled and extracted, avoiding the commonly encountered problem of soft tissues, particularly omentum, occluding the nozzle.

COMMENTS ON:

JP Pracy, JC Watkinson. Surgical tracheostomy – how I do it. *Ann R Coll Surg Engl* 2005; **87**: 277–82

COMMENT 1

doi 10.1308/003588406X106388

The use of the laryngeal mask in surgical tracheostomy

MH CLARK¹, DR BALL²

Departments of ¹Oral and Maxillofacial Surgery and ²Anaesthesia, Dumfries and Galloway Royal Infirmary, Dumfries, UK

CORRESPONDENCE TO

Dr David Ball, Consultant Anaesthetist, Departments of Anaesthesia, Dumfries and Galloway Royal Infirmary, Dumfries DG1 4AP, UK
E: dball@nhs.net

We enjoyed the description of surgical tracheostomy which we feel will be of benefit to trainees of many different specialties. We should like to recommend the use of the flexible laryngeal mask airway (LMA) for selected cases as an alternative to tracheal intubation or local anaesthesia. The LMA has a number of advantages. First, there is no tracheal tube cuff within the surgical field, which, if damaged, risks impaired gas exchange to the patient. Cuff damage can also lead to formation of a bloody aerosol as positive pressure ventilation continues through the tracheal incision.

Second, a tracheal tube must be carefully withdrawn to allow placement of the tracheostomy tube. This results in disturbance to the surgical drapes. We emphasise that this can lead to premature extubation of the patient's trachea at a critical moment, with the very real risk of ensuing hypoxia.

Third, the placement of a tracheal tube within the patient's airway can allow oropharyngeal secretions to