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

accumulate within the larynx and trachea, above the cuff. When the cuff is deflated, these secretions may contaminate the proximal trachea and bronchial tree. The LMA protects against this. Finally, the LMA avoids tracheal intubation, which may be technically demanding in this patient group.

Case selection is important. Use of the LMA is inappropriate when a patient has a full stomach, low respiratory compliance (leading to high inflation pressures during mechanical ventilation) or periglottic pathology which interferes with correct placement of the LMA.

LMA for tracheostomy was originally described in 1992,¹ and a case series reported recently.² We find that the flexible ('re-inforced') LMA is the most suitable because the flexible nature of the airway tube allows it (and the attached breathing system) to be positioned out of the operative field.

References

1. Thompson KD. Laryngeal mask airway for elective tracheostomy. *Anaesthesia* 1992; **47**: 76.
2. Gibbons AJ, Evans MJ, Fenner SG, Grew NR. The use of the laryngeal mask airway in surgical tracheostomy. *Br J Oral Maxillofac Surg* 2005; **43**: 89–90.

COMMENT 2

doi 10.1308/003588406X106397

Percutaneous tracheostomy

MARTIN H THOMAS

Department of Vascular Surgery, St Peter's Hospital, Chertsey, Surrey, UK

CORRESPONDENCE TO

Mr MH Thomas, Department of Vascular Surgery, St Peter's Hospital, Guilford Road, Chertsey, Surrey KT16 0PZ, UK.
E: martin.thomas@doctors.org.uk

I enjoyed this article on surgical tracheostomy describing the authors' obviously excellent, meticulous and elegant technique. However, there is no doubt in my mind that the procedure of choice in the intensive care unit (ITU), where most tracheostomies are performed, is the percutaneous method.

The authors suggest that the surgical procedure should be carried out in an operating theatre, and herein lies the problem. ITU patients are like Algerian wine – they do not travel well. Moving such a patient to the operating theatre from ITU can be a major undertaking, requiring an anaesthetist, an ODP, a nurse, a porter and perhaps even a distraught relative. For this reason, I carried out 104 consecutive surgical tracheostomies at the bedside in ITU, rather than in theatre. The wide bed should not put the surgeon off. The procedure still requires instruments brought from

theatre, a diathermy machine, a dedicated sucker, proper lighting, a nurse, an ODP and perhaps an assistant. There was one death directly attributable to the operation; minor bleeding and postoperative infection were common.

I then switched to percutaneous tracheostomy, having been trained by an ITU consultant colleague in another hospital. The technique is quicker and easier, requires no extra instruments, no assistant and no operative surgical skills. In a personal series of 94, one patient died from a cardiac arrest as the procedure started. Minor complications and infective problems have been minimal. Furthermore, most of the percutaneous tracheostomies are now performed by the ITU staff. Since introducing percutaneous tracheostomy, we have only required to perform one open surgical tracheostomy on an ITU or HDU patient and this was done for us by an ENT surgeon.

AUTHOR'S RESPONSE

doi 10.1308/003588406X106405

JPM PRACY

Department of Otolaryngology, The Queen Elizabeth Hospital, Edgbaston, Birmingham, UK

CORRESPONDENCE TO

Mr JPM Pracy, Consultant Otolaryngologist/Head & Neck Surgeon, The Queen Elizabeth Hospital, Edgbaston, Birmingham B15 2TH, UK. E: lucie.wright@uhb.nhs.uk

We are in agreement with Mr Thomas as to the performance of percutaneous tracheostomy at the bedside for simple, straight-forward ITU cases and indeed there is extensive literature to support this point of view.

It is certainly the case that it is preferable not to transfer patients from ITU to the operating theatre. However, the majority of patients who now undergo a formal, open, surgical tracheotomy are patients with complex anatomy or medical problems and we feel that these are best dealt with in the environment of an operating theatre.

Having said this, as is always the case, a risk–benefit analysis needs to be carried out in one's own mind as to the risks of patient transfer against the risks of complications during a procedure that is being carried out in a less than ideal environment. It is certainly possible to carry out a tracheotomy at the bedside in ITU; however, the width of the bed is not to be underestimated as this requires the surgeon to lean over much further than is normally the case, resulting in low back pain, and it may indeed be the case that there are health and safety issues for the surgeon and/or assistant.

We do not feel that people should be proscriptive about either the technique or place where the tracheostomy is carried out.