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

doi 10.1308/003588405X51173

von Arx OA, Brooks RA. A simple technique to reduce fogging of a standard visor face mask. *Ann R Coll Surg Engl* 2005; **87**: 387

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Use of a double face mask

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Although this seems to be an effective method for mask ventilation, there may be concerns regarding the risk of 'splash back' of blood, especially during orthopaedic surgery.

Figure 1

Figure 2

A recent article presents a novel way of mask application which not only reduces fogging but also considerably reduces the amount of 'splash back' into the faces of the surgeon and assistants.¹

The technique (Figs 1 and 2) involves placing a face mask on in the conventional manner and another mask turned upside down. The second mask is placed at the level of the forehead with the plastic visor pointing inferiorly.

Reference

1. Loveridge JM, Gozzard C, Bannister GC. The effectiveness of a visor as a surgical barrier: an inverted position is better. *J Hosp Infect* 2006; **62**: 251–3.

COMMENT ON

doi 10.1308/003588405X71072

AK Singh, JA Oni. Simplified method of skin closure with a knot-free absorbable subcuticular suture. *Ann R Coll Surg Engl* 2005; **87**: 471–2

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Cautionary observations on stitching with absorbable sutures

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The described technique is innovative and anything that reduces the amount of buried foreign material is to be encouraged. However, there is no detail as to the exact level within the dermis where the suture should be placed. One sees early on in wounds that should heal with almost negligible scarring (thyroid surgery, lower transverse abdominal incisions) an excellent scar with subcutaneous sutures. At 6 months onwards, however, these scars become hypertrophic and occasionally keloid. This may be due to the suture material being placed too superficially in the dermis to make sure the epidermis is well opposed. The

skin closure tension should be managed with deeper dermal sutures. The epidermis may come together without any further suturing but re-enforced with tape.

There are some patients who are sensitive to the various absorbable sutures used for skin closure. The tissue reaction settles when the sutures are removed without antibiotics.

The newer suture materials (*e.g.* Vicryl™ rapide [Polyglactin 910]; Ethicon, Simpson Parkway, Kirkton Campus, Livingston EH54 0AB, UK) have become popular for skin stitching, particularly as it is common practice not to remove them. However, these sutures often remain longer in place than the perceived seven days. This often results in stitch marks, which should be avoided. If, however, these materials are used as skin stitches, then, particularly in children, the knots can be cut. The parents/patient can then be encouraged to rub out the remaining stitch ends over the next few days. The best time to do this is at bath time. Supportive tape can be applied if there is concern about the strength of the healing wound.

AUTHOR'S RESPONSE

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The recommended suture technique uses the deep dermal layer to approximate the wound edges, thereby ensuring that minimal tension is put on the superficial layer. We did not use any strips/tape and there is no evidence in the scientific literature to justify or support the practice of closing a surgical wound with both subcuticular suture and adhesive surgical tape.¹

Taped closure alone has advantages of lower wound infection rates and greater wound tensile strength but disadvantages of epidermal reaction, skin edge inversion, doubtful safety and time required for meticulous surgical technique.²

References

1. Yavuzer R, Kelly C, Durrani N, Mittal V, Jackson IT, Remine S. Reinforcement of subcuticular continuous suture closure with surgical adhesive strips and gum mastic: is there any additional strength provided? *Am J Surg* 2005; **189**: 515–8.
2. Kolt JD. Use of adhesive surgical tape with the absorbable continuous subcuticular suture. *Aust NZ J Surg* 2003; **73**: 626–9.

COMMENT ON

doi 10.1308/003588406X82970

JB Webb, A Khanna. Can we rely on a general practitioner's referral letter to a skin lesion clinic to prioritise appointments and does it make a difference to a patient's prognosis? *Ann R Coll Surg Engl* 2006; **88**: 40–5

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Referral letters

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Whether the paper by Webb and Khanna with its confusing numbers and contradictions contributes to an evaluation of the rapid referral scheme for suspected cancer is doubtful.

When a two-week referral proforma is used, there is an obligation on the part of the hospital clinician to at least see the patient within two weeks of the receipt of the referral. There is no need, as implied in the paper, to mark such a referral as urgent. Likewise, it is superfluous to indicate urgency in a referral letter that suggests that a patient has malignant melanoma!

Of the 204 referrals received, 56 patients were discharged, leaving 148 patients, but we are told of only 133 patients who were recommended to have surgery. No mention is made of the four patients out of ten in the benign group. Further along, there are 69 patients where the GP thought the lesion was benign and 123 patients where the GP considered malignancy, making a total of 192.

However, of the 69 patients with a presenting diagnosis of a benign condition, surgery was performed in 43 (62%) with histology showing malignant/premalignant lesions in 5 (7%).

Of 123 patients that the GP thought had malignancy, surgery was planned in 80 (65%). Histology showed malignant/premalignant lesions in 33 (41%). Therefore, there is also 93% accuracy by the GP in the diagnosis of non-malignant conditions.

Additionally, there has not been a significant increase in workload from 1999 to 2003. The two-week rule has not always affected routine waiting times, which in some instances have improved.¹

That a GP needs to use the referral proforma appropriately is important. It is unfortunate that this paper contains