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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ANJANI SINGH

CORRESPONDENCE TO

AK Singh, 2 Forest Rise, Desford, Leicester LE9 9DX, UK
E: singhanjani@hotmail.com

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

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COMMENT ON

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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

NK MENON

The Ongar Surgery, Ongar, Essex, UK

CORRESPONDENCE TO

NK Menon, The Ongar Surgery, High Street, Ongar, Essex CM5 9AA, UK
T: +44 (0)1277 363976; F: +44 (0)1277 365115;
E: kenmenon@aol.com

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