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

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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

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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 135 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

confusing information while seeking to imply that there is abuse by GPs of the referral system. Primary care personnel, like those in secondary care, are under increasing pressure to investigate/refer patients partly fuelled by public concern about cancer and from the risk of litigation. Coupled with this is the considerable uncertainty with which primary care physicians have to work.

Referral guidelines are there to identify the majority of patients with cancer. There will always be patients who fall outside guidelines but who are a source of concern in primary care and who, nevertheless, need to be seen urgently. It is this group in whom it is vital to mark the referral letter as 'urgent' or even to speak to the relevant consultant prior to dispatch of the letter. It is imperative that hospital personnel look at work patterns and lobby for increase in resources while supporting a reasonable and safe shift from secondary to primary care. Patient education should remain an integral part of any scheme to improve the care of patients with cancer.²

References

1. Walsh S, Bruce C, Bennington S, Ravi S. The fourteen-day rule and colorectal cancer. *Ann R Coll Surg Engl* 2002; **84**: 386–8.
2. Eccersley AJ, Wilson EM, Makris A, Novell JR. Referral guidelines for colorectal cancer – do they work? *Ann R Coll Surg Engl* 2003; **85**: 107–10.

AUTHORS' RESPONSE

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We agree that when a two-week referral proforma is used there is an obligation on the part of the hospital clinician to see the patient within two weeks of the receipt of the referral. We also agree that the GP needs to use the referral form appropriately and acknowledge Dr Menon's views about the need to increase resources.

However, we do have concerns that despite the fact that basal cell carcinomas (BCCs) are not included as a cancer for the UK Department of Health statistics, 9 of the 58 urgent referrals were for patients who the GP suspected a BCC. The GPs may be disregarding guidelines on clinical grounds, due to pressure from the patient or from lack of

experience. We agree with Dr Menon that, in the case of a patient requiring an urgent referral who falls outside the guidelines, it is prudent to speak to the relevant consultant surgeon or give clarification in the referral letter.

We acknowledge that the accuracy of diagnosis for non-malignant conditions is 93%; however, of the 58 urgent referrals, there were only two patients with lesions that come under the skin cancer guidelines, which is an accuracy of only 3%. Unfortunately, 3% of the non-urgent referrals also had lesions that come under the skin cancer guidelines. This may be just an unfortunate set of referrals but the large proportion of urgent referrals (28%) does represent a significant workload for the secondary carers and may also be indicative of insufficient exposure to skin diseases within the training of GPs.

Our second concern is how to prioritise the patients whose referral letter, which is either marked as routine or has no priority specified and is not faxed through the normal urgent referral route, indicates no history or examination, only the patient's concern regarding a 'mole' and could it be 'melanoma'? We agree that if there is a question of malignant melanoma then the request for urgency is superfluous. However, when such a referral is specified as routine, or is not sent through the urgent route, it would be useful to know that the GP, in fact, has a low index of suspicion and the referral is for a second opinion to allay the patient's worry. In the previous system, a referral with a concerning history, examination or proposed diagnosis would have been seen urgently. In the current system, where does the responsibility lie if a patient has a delayed diagnosis of malignant melanoma because the appointment is given as routine, even though the history is suspicious but the GP marks the referral as routine?

We disagree that the information provided was contradictory; however, we can understand that some of the tables may appear confusing initially. For example, there is a total of 192 rather than 204 when comparing the referral letter's diagnosis because 12 had insufficient information to infer a benign or malignant suspicion. There is also a variation in totals when comparing 'malignancy' with appropriate urgent referrals because of the exclusion of BCC for the urgent referrals.

We have not sought to imply that GPs abuse the referral system but to highlight the inconsistencies that easily arise with the current system of referrals. Indeed, we have tried to highlight that, in our experience, while there is a need for more detailed information in the referral letter, the prognostic stage for melanoma patients at diagnosis is unaltered since the introduction of the 2-weeks wait.

We are pleased that our paper has stimulated some much-needed debate and, therefore, has clearly contributed to the evaluation of the rapid referral scheme for suspected cancer.