COMMENT ON

doi 10.1308/003588406X98531

B Levy, A Charkin. A revised guide-wire technique for urethral catheter insertion. *Ann R Coll Surg Engl* 2006; **88**: 228–9

doi 10.1308/003588406X149408

A better way to insert urethral catheter with guide-wireVINCENT CY TANG¹, SIMON RJ BOTT²

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Levy and Charkin described the longitudinal cut at the tip of the catheter to allow the guide-wire to pass through for rail-roading into the bladder. This method maintains the manufactured conical shape of the catheter tip, hence the ease of advancement. However, the longitudinal cut to the tip of the catheter can potentially cause the catheter to bivalve and split, which can lead to urethral trauma.

An alternative technique, using a 14-gauge (Brown) intra-venous cannula needle threads through the side drainage hole of the urethral catheter and then punctures the centre of the tip of the catheter to form a track; the guide-wire is subsequently passed retrograde through the intravenous cannula needle. The needle is removed which allows the guide-wire to pass into the central catheter drainage lumen. After lubricating the guide-wire and the urethral catheter with lignocaine gel, the catheter is passed into the bladder over the guide-wire. From our experience, this method is easy to use, and also maintains the integrity of the shape of the catheter with no risk of the above complication.

AUTHORS' RESPONSE

doi 10.1308/003588406X149417

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We have never experienced the theoretical problem of the

catheter splitting. We believe this is because the slit made in the catheter is small as it only needs to allow a guide-wire to pass through. We do agree though that a long slit could potentially cause the catheter to bivalve and, hence, cause further trauma. Therefore, the slit should be kept as short as possible to allow the guide-wire to pass through.

The technique described involving the guide-wire being passed through the side drainage hole and then through the tip of the catheter using a 14-G intravenous cannula is an alternative technique. The problem we have had with this approach is the difficulty in advancing the catheter over the guide-wire. As the authors state, the guide-wire and catheter must be well lubricated: if not, the catheter catches on the guide-wire due to the oblique angle that it runs through the distal catheter. Advancement is then very difficult and one is uncertain whether the resistance is due to the guide-wire or due to urethral narrowing.

COMMENT ON

doi 10.1308/003588406X94878

J. Gosling, ES McKain, S Dumont, BM Stephenson. Lost 'swab' at inguinal hernioplasty under local anaesthesia. *Ann R Coll Surg Engl* 2006; **88**: 161–2

doi 10.1308/003588406X149426

Another advantage of the laparoscopic approach

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Originally, the National Institute for Clinical Excellence (NICE) recommended laparoscopic inguinal hernia repair for bilateral and recurrent hernias. However, on 23 September 2004, the NICE Technology Appraisal Guidance No. 18 stated that the laparoscopic approach was suitable for all inguinal hernias. In 1998, Wellwood *et al.*¹ published a randomised control trial comparing open tension-free mesh hernioplasty under local anaesthetic with transabdominal preperitoneal laparoscopic hernia repair under general anaesthesia. Patients' perception of health one month post-surgery and patient satisfaction were superior in the laparoscopic group and the convalescent period shorter. There will, of course, always be a place for open repair under local anaesthetic in patients who are unfit for general anaesthesia, or indeed patients who request this technique. However, the laparoscopic approach

would seem to be superior and, in this particular case, there is no suggestion that the patient is unfit, or indeed requested a local anaesthetic repair. The fact that intra-operative swabs are not placed within any body cavity during a laparoscopic hernia repair means that this feared complication of a retained swab cannot occur. Is this yet another advantage of having a laparoscopic repair?

Reference

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AUTHORS' RESPONSE

doi 10.1308/003588406X152080

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We note the recent comment regarding our short report is entitled 'Another advantage of the laparoscopic approach'. We do not feel that this is true and, indeed, more up-to-date references^{1–5} than they quote do not support their anxieties regarding repairs under a local anaesthetic as supposed to the benefits of a laparoscopic repair. Furthermore, the correspondents miss the point regarding the clearly demonstrated value of pre-emptive analgesia. The jury is still out!⁶

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BOOK REVIEW

Ann R Coll Surg Engl 2006; **88**: 000–000

doi 10.1308/003588406X152134

Alarm Bells in Medicine: Danger Symptoms in Medicine, Surgery and Clinical Specialties

NADEEM ALI

EXTENT P/H	192 p, paperback
PRICE/ISBN	£19.95 0727918192
PUBLISHER	BMJ Publishing (London), 2004
REVIEWER	Andrew Edwards
STAR RATING	****

This book presents the reader with an overview of symptoms in medicine and surgery that should alert them to a possible underlying serious condition. The editor has been able to draw on the experience of a wide range of world-wide contributors, all renowned experts in their own individual fields. What makes this book unique is that there are no references as such; acknowledgement of each contribution is indicated at the beginning of each section.

There are no chapters in the book, only sections attributed to each individual subject. They are listed alphabetically from breast surgery through to vascular surgery. At the beginning of each section there is a list of the ten top 'alarm bells' for each subject. The following pages expand on these in more detail, giving the salient features of each symptom and a recommended course of action.

The individual specialties identified are comprehensive. However, I feel that radiology and pharmacology could have been included as well. Each of the authorities in their field has given a list of the top ten symptoms, which no doubt will cause disagreement within their own area, but I feel that each specialty has covered the more important and potentially serious symptoms very well. The action for each symptom follows a familiar line but also the degree of urgency and some interim advice is also given for each symptom. On the whole, there is no ambiguity as regards a diagnosis for a presenting symptom; therefore, the reader is left in no doubt as to the course of action to be taken.

The layout of the book and uniformity of the text make it easy to use. It is concise and very easy to retrieve information due to the alphabetical listing. There are no illustrations to accompany the text; this may add to the impact value but it does not detract from the purpose of this book. As mentioned, there are no references, only a list of distinguished authors of textbooks in their own specialty.

In summary, this is a valuable and well-edited collection of potentially serious specialty-specific symptoms. It is highly informative and should alert the reader to the 'alarm bells' that may present in their clinical practice. The book should prove a valuable asset to the library of anyone involved in the practice of medicine including medical students, GPs and hospital doctors.