Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the Notice printed on the inside back cover. 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 to subedit contributions to ensure clarity.

*Response from authors to letter about paper by
ML Rogers et al. on:*

Surgical treatment of para-oesophageal hiatal hernia

Ann R Coll Surg Engl 2001; **83**: 394–8

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We thank Palazzo, Hashemi and Cochrane (*Ann R Coll Surg Engl* 2003; **85**: 141) for their interest in and comments about this paper. There are, undoubtedly, a very large number of patients within the community who have large para-oesophageal hiatal hernias which are either asymptomatic or with symptoms that are either ignored or undiagnosed. The risk remains of strangulation and perforation. Many of these patients are elderly and with significant co-morbidity. We would agree with the selective approach to surgery within the context that strangulation and perforation may well be fatal complications and it is often safer to perform elective repair in non-emergency cases. We are perhaps biased in favour of surgery as we have few local competitors for this kind of emergency surgery.

We would agree that we rather assume that recurrences are few, but our field is thoracic surgery. Whilst crural fibres appear rather thin, attenuated and unsuitable for surgery via the abdominal approach, the view from the thorax is very different and we very rarely need to use more than interrupted silk sutures to provide a secure repair. We also have a very low threshold for performing an anti-reflux procedure at the same time. This is because we feel that reflux would otherwise be very likely postoperatively and because we believe the result is a more secure repair. Unfortunately, we sometimes get it wrong.¹ We would regard final placement of a fundoplication in the chest as a surgical failure.

As thoracic surgeons, we have concerns regarding the wisdom of laparoscopic repair. Whilst large rolling para-oesophageal hiatal hernias can usually be repaired safely and simply through the chest, they can also be technically quite challenging. Whilst we would applaud the enthusiasm of laparoscopic surgeons in attempting these, the experience of others² leads us to continue as we have been doing.

References

1. Kotidis KN, Rogers ML, Knowles KR, Beggs FD. Coexisting achalasia and paraoesophageal hiatal hernia. *Eur J Cardiothorac Surg* 2002; **21**: 130–2.
2. Dahlberg PS, Deschamps C, Miller DL, Alien MS, Nichols FC, Paiolero PC. Laparoscopic repair of large paraesophageal hiatal hernia. *Ann Thorac Surg* 2001; **72**: 1125–9.

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Response to paper by Godpole and Stringer

Splenectomy after major trauma: could more spleens be saved?

Ann R Coll Surg Engl 2002; **84**: 106–8

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We would like to commend the authors of the paper for their study of paediatric injury in the region. While the paper deals specifically with the management of splenic trauma, the paper has serious implications for the management of major trauma in general.

No child in the study required a splenectomy, according to standard guidelines for non-operative management of splenic injury. All became haemodynamically normal after minimal fluid resuscitation, none required a blood

transfusion, none developed signs of peritonitis and there were no other indications for laparotomy. Only one child had an emergent CT scan of the abdomen – the standard investigation for splenic injury in the haemodynamically stable child and a requirement of the latest NCEPOD report for hospitals receiving paediatric trauma patients.¹ Three children underwent laparoscopy – an unnecessary, unhelpful and potentially hazardous investigation in blunt trauma patients.

In their discussion, the authors write '*our survey revealed that children having splenectomy for trauma...received expert operative surgery*'. This is clearly not the case. Trainees performed 4 cases, and it is unlikely that any of the involved surgeons had a specialist interest in trauma surgery. The patient with a pancreatic fistula, who subsequently required a distal pancreatectomy, either had a missed injury at the initial laparotomy or a pancreatic injury occurred during the splenectomy.

It is hardly surprising that these children were subject to poor decision-making and inappropriate investigations and sub-optimal operative interventions. In a 5-year period, only 11 children from 10 hospitals underwent emergency splenectomy. This is one child per hospital every 5 years, or one child per surgeon every 25 years (assuming a 1-in-5 on-call rota). This would not be considered acceptable in any other surgical specialty.

All these children should have been delivered, either primarily or secondarily, to a regional specialist trauma centre. The infrequent cases where splenectomy is necessary must be identified early and managed

expediently. The conduct of a trauma laparotomy and splenectomy is wholly different from a standard splenectomy in elective cases. Only centres seeing such patients on a routine basis will have the personnel and resources available to manage these patients optimally.

Until trauma is recognised as a clinical entity in the UK, trauma surgery is developed as a speciality, trauma systems are developed on a regional basis, and legislation for the practice of trauma care implemented at government level, such cases of substandard treatment will continue. The Royal College of Surgeons of England attempted to define minimum standards with their document *Better Care for the Severely Injured* in 2000.² However, we can see little indication of any change for the better in the subsequent 2 years, and studies like these highlight the urgent need for improvement in our approach to trauma care in the UK.

References

1. The Royal College of Surgeons of England. Extremes of Age. The 1999 Report of the National Confidential Enquiry into Perioperative Deaths. London: The Royal College of Surgeons of England, 1999.
2. The Royal College of Surgeons of England. Better Care for the Severely Injured. London: Royal College of Surgeons of England, 2000.

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