commentary thus is limited in its efficacy. The site excels in its detailed account, via slide-show and video format with commentary, of the differing laparoscopic instruments that are used and essentially demonstrates how to use them. It is an easy site to navigate and provides a useful insight to the procedure. Definitely worth viewing.****

<http://www.gallbladder-surgery.info/download/flash.html>

The Society of American Gastrointestinal and Endoscopic Surgeons gives information regarding laparoscopic gallbladder removal. This macromedia flash presentation is solely directed at patients suffering from biliary symptoms awaiting the operation. It is an excellent presentation that gives an easy-to-understand, but detailed, presentation to patients. It answers most questions that patients may have. The clinician will find this a useful site to recommend to their patients suffering from biliary disease. The visual aids must surely give patients a better understanding of the disease/surgery.***

<http://www.edu.rcsed.ac.uk/HowIDoit/laparoscopic%20cholecystectomy.htm>

This article by Professor Cushieri is found on the Royal College of Surgeons Edinburgh surgical skills and knowledge website. This document provides a good insight into performing the surgery with the aid of diagrams. It is well worth viewing this as a quick guide to performing the procedure.***

Rosacea and rhinophyma

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<http://www.patient.co.uk/showdoc/40001034/>

Using the Google search engine, this is an easily accessible website. It has an in-depth area called patient plus, ostensibly written for doctors, which was by far the most informative part of the website. Overall, the site is well laid out, with good colour photographs, and presented in a format familiar to most doctors. It could perhaps have been more descriptive and optimistic in the treatment of rhinophyma, although it is well referenced.***

www.plasticsurgery4u.com/procedure_folder/rhinophyma_folder/rhinophyma.html

This site was set-up by Dr Michael Bermant, Board Certified by The American Board of Plastic Surgery. The site appears fairly lightweight and lacking in authority and some of the information is erroneous, *i.e.* 'Rhinophyma has been associated with many causes such as the over-consumption of alcohol'. The site does, however, discuss treatment options, concentrating on surgical management, with good before and after photos of dermaplaning and dermabrasion, but glosses over the role of lasers in treatment

of rosacea and rhinophyma. On the whole, it is quite a poor site considering the prominence it is given in search engine hits, with some information omitted or just plain wrong.*

<http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=325&sectionId=1998>

The NHS Direct site is set-up in a clear and easily navigable fashion. It is relatively comprehensive, although there is little here to recommend it to medical practitioners. The site certainly performs well as a basic starting point for someone researching rosacea, but does little to explain rhinophyma, and the paucity of photographic information is a definite weakness.***

www.cosmeticprocedureguide.ca/rhinophyma.html

An excellent site, part of the Skin Care Guide site, it provides information on the causes and effects of rosacea and rhinophyma in a way that is accessible to both doctor and patient. It explains the procedures involved and, though it has an understandable tilt towards surgical intervention, covers them well. One criticism is the omission of non-surgical interventions for rosacea.****

www.nlm.nih.gov/medlineplus/ency/article/001037.htm

This site is very brief and concise, without erroneous information, but anyone researching the topic will, of necessity, need to look elsewhere.**

<http://www.emedicine.com/derm/topic377.htm>

This article written by Agnieszka Kupiec-Banasikowska MD, Consulting Staff, Division of Dermatology, Georgetown University Medical Center and edited by multiple dermatological luminaries provides, as one might expect, a very thorough and comprehensive explanation of the aetiology, treatment and prognosis of rosacea, but less so for rhinophyma. Its strength is also perhaps its only weakness, in so far as the dense medical language used would make it difficult for a layman to interpret, and may initially appear forbidding. While separate articles on dermabrasion, and laser resurfacing within the site are expertly written, they are quite general about which conditions may be treated, and anyone looking specifically for information regarding rhinophyma may well be overwhelmed.***

www.rosacea.org/

This website, which is home to The National Rosacea Society, is on first appearance a poor attempt at an educational website, plastered with obtrusive banners and superficial taglines which can be immediately off-putting. With perseverance, there is access to information for both physician and patient in separate areas on the site. While it may be idealistic to expect websites without the invasive presence of advertisements, they negatively impacted on the image of the site, and lessened the feeling of authenticity of the information presented.**

www.rosacea.co.uk

Any hopes that a British website would be free of pervasive advertisements were quickly dashed. This quite amateurish

website is merely a list of endorsements or warnings from treated patients writing about their treatment experiences. While it may provide some sense of community to rosacea sufferers, the information it provides is the worst of any of the sites reviewed. It fails to give even the most basic medical information about rosacea and rhinophyma, and relies on hearsay and personal testimonies for its content.*

Endovascular aneurysm repair (EVAR) for abdominal aortic aneurysm (AAA)

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Abdominal aortic aneurysms (AAAs) are common in the industrialised world, causing 2% of all male deaths over 55 years of age, with a male to female ratio of 4:1. Risk factors are essentially those of atherosclerosis (tobacco use, hypertension, male sex and a family history of AAA). Rarer causes of aneurysms include infection, trauma, arteritis and connective tissue disorders such as Marfan's and Ehlers-Danlos syndrome.

Treatment has traditionally been surgical, performed for over 50 years via laparotomy, by clamping the aorta above and below the aneurysm, and anastomosing a tubular inlay graft to the normal calibre artery above and below the aneurysm, thus excluding it from the circulation. Operative mortality of this procedure in the emergency setting is in excess of 50%. Mortality is greater than 99% in the event of peri-operative cardiac arrest. Mortality associated with elective AAA repair is just under 5%.

Juan Carlos Parodi pioneered the endovascular approach to infrarenal aneurysm exclusion in Argentina, publishing a series of five patients (deemed anaesthetically unfit for open surgery) whom he had successfully treated via a femoral endovascular approach in 1991. Perhaps due to the wide familiarity and acceptance of the open operation, its conceptual simplicity and on-going role, the technique of EVAR met initial resistance; however, during the intervening 15 years, significant advances have been made.

An endoluminal approach to exclude aortic aneurysms is now becoming increasingly common in the UK, predicated upon the two-thirds' reduction in 30-day mortality compared to open repair. Patients are increasingly aware of the technique and the widely publicised EVAR 1 Trial demonstrating the decreased 30-day mortality (from 4.7% with the open technique to 1.7% using EVAR).

<http://www.evartrials.org/summary.htm>

The official Trial website contains a useful patient introduction with simple illustrations as well as a brief results summary of the

EVAR 1 and 2 multicentre randomised controlled trials. The key result showed reduced 30-day mortality of EVAR for those fit for open surgery (EVAR 1) from 4.7% to 1.7%. Conversely, 30-day mortality for EVAR in those patients considered unfit for open surgery (EVAR 2 trial) was 9%, with no long-term survival advantage or increased quality of life. These peri-operative deaths were, however, largely cardiac, cerebrovascular, pulmonary and renal rather than aneurysm-related and, at the time of the Trial risk-factor optimisation (aggressive control of hypertension, use of aspirin and statins) was poor in this cohort of patients. The site is useful for patients and practitioners having to decide between the two approaches.****

<http://www.evtoday.com/AAA/2004%20Files/Update%20on%20the%20EUROSTAR%20Registry.html>

This site has an extremely useful review of the EUROSTAR (EUROpean collaborators on Stent/graft Techniques for aortic Aneurysm Repair) registry; an open-ended audit of clinical outcome, collating data from over 6000 patients who have undergone EVAR for infrarenal AAA, at 110 participating centres since 1997. Aneurysms are subdivided by diameter into groups: A = 4.5–5.4 cm; B = 5.5–6.4 cm; and C = 6.5 cm. Larger aneurysms (C) were found in an older population group with higher renal, cardiac and pulmonary co-morbidity; they were also associated with larger infrarenal neck diameters and more tortuous arterial trees making placement of stents more technically challenging. Perhaps unsurprisingly, these largest aneurysms, when treated with earliest stent types, had significantly poorer long-term outcome, with an exponential rise in the rate of aneurysm-related death reaching 12% at 6 years. These were chiefly associated with a tendency for distal migration (causing type 1 endo-leak) and material fracture (causing type 3 endo-leak), problems that have been substantially overcome by the newer generation of devices. Type II endo-leaks (from aortic side branches communicating with the excluded aneurysmal sack) by contrast, were found to have no significant adverse effect provided they were not associated with increasing sac size (which is usually the case). Despite these early difficulties with larger aneurysms, the EUROSTAR registry shows excellent results for smaller aneurysms, with 0.002 aneurysm-related deaths per patient year in group A and an overall freedom from aneurysm-related death in the entire study cohort of 97% at 4 years. The site is tremendously useful for practitioners having to advise patients on the relative merits of EVAR and open repair.****

<http://www.medterms.com/script/main/art.asp?articlekey=38676>

This on-line medical dictionary has a useful entry pitched for layperson or patient introduction. Keywords prompt further explanatory texts (similar to Wikipedia), though these are not always very helpful. This site quotes reasonable figures for 30-day mortality of 4–12% for elective open AAA repair which 'decreases by 2/3 but with a higher rate of re-operation using EVAR.***