and two related to relief. Firstly, good information should be given to parents, schools, and children and should include the dangers of cannabis (memory impairment, the fact that it contains more carcinogens than tobacco, etc). Secondly, drugs should be eliminated. The police are on the right track in the way that they tackle big dealers, but they should be allowed to tackle street dealing as well, because it is difficult to find drugs when petty sales are reduced.³ Thirdly, users should be able to gain admission to drug free institutions where they are treated with respect and encouragement so that they can regain their self respect. Finally, good aftercare is necessary: any former user should have a counsellor, who could help him or her find accommodation and a job. Weekly urine checks are advisable so that any relapse can be recognised.

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Evaluating new surgical procedures

Hip replacements come in at least 10¹¹ varieties

EDITOR,—I strongly support Ian Russell's call for collaboration between surgeons and trialists.¹ Russell makes many important points, but three additional questions should also be asked when surgical procedures are being evaluated: which?, how?, and when? These are particularly relevant to surgery for trauma and in orthopaedics. An example is total hip replacement operations. Not all such procedures are the same; there is no practised consensus on hardware or method.²

Which?—At least 62 different total hip replacements are available in Britain.³ Many are modular, permitting the use of different sizes of femoral head with different materials at the surgeon's discretion, which allows further multiple variation.

How?—In the past six years I have worked for 17 consultant orthopaedic surgeons, who have all used a different, unique method for total hip replacement operations. The table shows the number of possible variations at various stages that I have learnt. The sum of the variations is 1.08×10¹¹. This is a conservative, theoretical estimate of the number of possible methods in total hip replacement operations. Each variation at each stage could alter the final outcome.

When?—A good result at five years does not always mean a good result at 20 years. The randomised controlled trial in surgery is the utopian

ideal that will provide evidence based surgery. This is the goal to which all surgeons should strive, though the challenge is enormous.

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Design of trials should depend on whether new skills are required

EDITOR,—We agree with Ian Russell¹ that the randomised trial is the design of choice for evaluating surgical procedures; this view has been reinforced by others.² Nevertheless, new surgical procedures should be studied in the context of the skills required to achieve them. If a new procedure requires the acquisition of new skills then the learning curve ought to be assessed. On the other hand, if the procedure is conceptually a new approach to a disease but requires traditional surgical skills then experienced surgeons ought to perform it; then it should be possible to randomise the first patient who undergoes the new procedure. Once a technique has been established as safe and effective and its widespread impact and efficacy are being studied it may be widely disseminated, but compulsory audit is essential.

Russell deems the blinding of patients and carers in randomised controlled trials to be irrelevant and impractical. If media publicity has imbued the minds of patients and carers with the advantages³ or dangers⁴ of a new operation then blinding becomes highly relevant. In practice, blinding patients and carers is not as difficult as people might think (AWM *et al*, annual conference, Harrogate, 20-22 April 1994). The use of multiple centres in such trials also needs to be carefully considered because, although recruitment is facilitated, the trials necessarily become loosely controlled.

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Few trials of laparoscopic cholecystectomy have been randomised

EDITOR,—We agree with Ian Russell that the randomised trial is the design of choice for evaluating new surgical procedures.¹ Russell points out

that there have been only about 10 trials comparing laparoscopic with conventional cholecystectomy but is incorrect in implying that these were all randomised trials and that only one randomised more than 100 patients.²

So far as we are aware there have been only three prospective randomised trials, two of which contained more than 100 patients. The first trial randomised 70 patients in five hospitals between eight surgeons in Canada,³ while the second randomised 299 patients in five hospitals between seven surgeons in Glasgow and Kilmarnock.⁴ Our series randomised 310 patients between one consultant surgeon and his trainee senior registrars and associate specialist on one surgical team in one hospital trust group.⁵

Russell does not mention one of the main problems that we have met in trying to publish our work, which has been the resistance of the already converted enthusiasts to any suggestions that the new procedure may not be as good as the experts suggest. Claims have been made that laparoscopic cholecystectomies are possible in 95-96% of cases, with the natural implication, therefore, that any surgeon not able (or willing) to achieve these figures must be untrained, unskilled, or, indeed, unsuited to the new technique.

The only way in which an ideal trial could be conducted would be for patients (unselected, of course) to be randomised by an independent agency and then referred to surgeons 1 and 2, who would be the recognised experts in each particular technique. The next best method would be for one surgical team or one surgeon, equally enthusiastic about both techniques and open minded and unbiased about the outcome, to be responsible for the whole trial. Multicentre trials are open to much hidden bias and unwitting selection and so are not as helpful to determine the true differences between procedures.

The series quoted by Russell as having more than 100 patients² was part of the Scottish series, in which 132 patients were randomised at five different hospitals (interestingly, between only six consultant surgeons at that stage in 1993).

In these prospective trials it is interesting to note that the rate of conversion from laparoscopic to open cholecystectomy is about 10%.

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Table 1—Possible options in total hip replacement surgery

Stage of procedure	Possible variations	Stage of procedure	Possible variations
Theatre environment	3	Acetabular preparation	6
Patient's position	3	Acetabular cementing technique	3
Skin preparation	4	Femoral preparation	8
Patient draping	6	Distal cement plug	2
Surgeon's gown	9	Femoral cementing technique	4
Skin drape	3	Closure	2
Towels	2	Antibiotic prophylaxis	3
Approach	7	Thromboembolic prophylaxis:	
Tray system	2	Chemical	4
Power instruments	2	Physical	4
Irrigation	3		

Treatment of acute anaphylaxis

Letters contained errors of logic

EDITOR,—The letters¹ about my article on acute anaphylaxis² show the difficulties of trying to provide simple algorithms when controlled trials are impossible and the pattern of symptoms and severity vary. Some of the replies contain errors of logic.

Glenis K Scadding emphasises the use of tourniquets to avoid further contact with the allergen. Such use is not supported by data and may be hazardous as release of arterial tourniquets pro-