Letters and comments

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COMMENT ON

doi 10.1308/003588407X183517

SM Blake, AE Cattell, CR Wetherley. Level determination in anterior cervical fusion. *Ann R Coll Surg Engl* 2007; **89**: 436

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Use of a stylet spinal needle

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We commend the authors for bringing to the general surgical and orthopaedic readership this technique of accurate level determination in anterior cervical fusion. However, in our neurosurgical practice over several years, we have a modification of this technique to overcome certain drawbacks of using a hypodermic needle. The policy in our unit is to use a 0.7 mm (22-G) x 90 mm (3.5 inch) stylet spinal needle with Quincke Type Point (BD Spinal Needle <www.bd.com>) available via NHS Supply Chain or from Southern Syringe (ref no. 405256; George House, Unit 6, Delta Park Industrial Estate, Milmarsh Lane, London EN5 7QJ, UK). This is similarly contoured as described by the authors. The advantages of this method are that:

1. Should the initial attempt at localisation be incorrect, the stylet within the spinal needle reduces damage to the cervical disc (which is to be preserved). The damage is more prominent with a hollow hypodermic needle.

2. The length of the spinal needle lets it project beyond the skin while taking radiographs (when the surgical wound needs to be covered to prevent contamination) and thus facilitates access to the cervical disc once the covers are removed again.

COMMENT ON

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Z Soonawalla, A Ganeshan, P Friend. Celiac artery occlusion encountered during pancreatic resection: a case report. *Ann R Coll Surg Engl* 2007; online case report

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Pre-operative endovascular stenting of the coeliac trunk

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The authors have re-implanted the coeliac axis to ensure adequate vascularisation of the upper abdominal viscera as a part of pancreaticoduodenectomy. This and various other techniques of dealing with an intra-operative diagnosis of either coeliac stenosis or occlusion have been described earlier.¹ However, the additional morbidity of major vascular reconstruction procedure needs to be carefully considered. With the availability of thin-slice CT scanning, it should be possible to make a pre-operative diagnosis of coeliac stenosis or occlusion either by direct visualisation of the trunk or by indirect means (abnormally large collaterals). Developments in endovascular stenting technology and expertise allow not only peripheral arterial stenting, but aortic, cerebral and visceral (including mesenteric) arterial revascularisation.² Thus, if there is a suspicion of occlusion or stenosis on pre-operative CT, mesenteric angiography can also be performed with a view to endovascular stenting prior to performing a pancreaticoduodenectomy. Even if the diagnosis of coeliac occlusion was made intra-operatively, retrograde stenting should still be considered if interventional vascular expertise is available.³

One of our recent patients being worked up for a pancreaticoduodenectomy to treat a pancreatic head malignancy