Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. 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 subedit contributions to ensure clarity.

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

Figure 1 Reconstruction of CT images demonstrating hypertrophic and enlarged gastroduodenal and pancreaticoduodenal arteries.

Figure 2 Endovascular stenting across coeliac occlusion.

was found to have a coeliac occlusion, detected on staging CT scanning. The give away was an abnormally enlarged gastroduodenal artery (Fig. 1). The diagnosis was confirmed by arteriography and pre-operative endovascular stenting of the coeliac trunk was performed (Fig. 2). At surgery, there was no difference in the CHA pulse or Doppler pressures and waveforms before and after clamping the gastroduodenal artery due to an adequate hepatic arterial inflow from the stented coeliac artery. This technique also allows single-stage pancreaticoduodenectomy with perhaps less morbidity than re-implantation of a major visceral artery.

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COMMENT ON

doi 10.1308/003588407X205521

S Chitale, RL Hudson. Technique of urethral catheterisation in very elderly women. *Ann R Coll Surg Engl* 2007; **89**: 635–6

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A simpler approach

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Although the described technique of using an introducer to aid the insertion of a urethral catheter in these patients seems simple and logical, we propose an even easier technique that does not require the use of an introducer.

First, the patient's legs are abducted and knees bent as for pelvic examination. Second, a two digit assessment (using the index and middle finger of the left hand) of the vagina is made to locate the urethral meatus along the anterior vaginal wall. If the urethra is found to be recessed, the index and middle fingers are angled anteriorly to guide the urethral catheter through the meatus. This technique has proved to be useful not only during the insertion of a urethral catheter, but also when performing flexible cystoscopy in the elderly.

COMMENT ON

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MD Pacifico, RA Pearl, R Grover. The UK Government two-week rule and its impact on melanoma prognosis: an evidence-based study. *Ann R Coll Surg Engl* 2007; **89**: 609–15

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Capacity and the two-week rule

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After reading this report, I could not help but feel that the conclusion reached that the 'two-week rule' has an evidence in melanoma survival was slightly misleading. I say this because it appeared that the introduction of the new Pigmented Lesion Clinic (PLC) was rather more causal than