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.

References

1. Berney T, Pretre R, Chassot G, Morel P. The role of revascularization in celiac occlusion and pancreatoduodenectomy. *Am J Surg* 1998; **176**: 352–6.
2. Atkins MD, Kwolek CJ, LaMuraglia GM, Brewster DC, Chung TK, Cambria RP. Surgical revascularization versus endovascular therapy for chronic mesenteric ischemia: a comparative experience. *J Vasc Surg* 2007; **45**: 1162–71.
3. Wyers MC, Powell RJ, Nolan BW, Cronenwett JL. Retrograde mesenteric stenting during laparotomy for acute occlusive mesenteric ischemia. *J Vasc Surg* 2007; **45**: 269–75.

COMMENT ON

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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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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

the 'two-week rule'. Would I be incorrect to claim that it was more likely that an increase in out-patient capacity as a result of this new clinic was rather more important than the Government's intervention? After all, if the two-week rule was introduced with no extra clinics or capacity, then the impact on melanoma survival may not have been so great and the extra volume of work may have resulted in a negative impact by delaying other cases that fall outside the reach of the two-week wait. The authors indeed pointed out that the two-week rule resulted in a huge increase in the number of suspected skin cancer referrals; this demonstrates that, if the two-week rule is introduced without a concomitant increase in capacity, the impact of the two-week rule may not be entirely positive. Undoubtedly, the new PLC and the two-week rule have worked well in this case; however, I feel that the context of the two-week rule is much more important than the rule itself.

AUTHORS' RESPONSE

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What Dr Dean says is true: Government targets and initiatives imposed on hospitals without the funding to increase service capacity are indeed often counter productive. The two-week rule is no exception and, in a number of cases, has demonstrated significant delays in cancer cases misdiagnosed as 'non-urgent'.¹

The Pigmented Lesion Clinic (PLC) described in the paper provides a practical way to deal expediently with the increasing number of referred cases, within the two-week time-frame. Of course, as is acknowledged in the paper, this particular clinic had the benefit of supernumerary research fellows to help staff the clinic. It is also true that some units without this luxury, and without funding for extra service provision, have had to close their PLCs due to the two-week rule.

However, the practical implementation of the two-week rule by hospitals in terms of service provision, and the evidence base (or lack thereof) behind the target itself are separate issues.

Currently, many targets in medicine appear to be decided without a proper evidence base. It was an aim of the paper to investigate the evidence behind this target by applying a two-week limit (retrospectively) to GP skin cancer referrals to see if adherence to this time-frame made a significant difference to the thickness of referred melanomas.

What was found was that a limit of two weeks from GP referral to specialist consultation, provided it was combined with swift progression to definitive treatment, did appear to make a difference to the thickness of melanomas excised. This has obvious implications for survival.

I agree that the funding to run a skin cancer service that can meet the Government's cancer targets is essential, otherwise the targets themselves exacerbate the problem. However, as clinicians, we must also be rigorous in examining the evidence base behind these targets, to ensure that the resources and manpower that is required to meet them is being directed to something that actually improves patient care.

Reference

1. Soo FY, Winterton R, Plusa SM. Impact of the '2 week rule' on the treatment of colorectal cancer. *Gut* 2001; **48**: A53.

COMMENT ON

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Consideration of mesh-related complications

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If 'better is the enemy of good', then both sides of the controversy for the use of mesh in hiatus hernia repair have missed the point.¹ The argument rests on whether what we do is already good enough. Kelty and Falk state that mesh repair would only be necessary in the 10–30% of patients who recur; this implies that all recurrences are symptomatic. This is not the case in our unit — in 322 consecutive patients who underwent para-oesophageal hernia repair without mesh, only eight patients (2.5%) required re-operation for symptomatic recurrence. Although the recurrent hernia rate for our series probably lies between 10–30%, it is symptoms that matter and 303 patients (94%) reported satisfaction with their surgery. As a specialist unit performing re-operations on mesh-related complications from other units, we strongly advise that