informed consent for elective mesh repair includes future oesophagectomy should problems occur. Failure to do so will eventually result in litigation and this fact alone should deter surgeons from 'banging a mesh in'. In contrast, re-operating on non-mesh cases, although challenging, is usually straightforward. In summary, we believe that non-mesh, para-oesophageal, hiatal repair is not far off 'good enough' and as Smith alludes – it will only be known through randomised evaluation of whether the placement of mesh is 'better'.

Reference

1. Voltaire. Le mieux est l'ennemi du bien. Dictionnaire Philosophique (1764). Penguin Classics 1984. ISBN-10:014044257X.

AUTHORS' RESPONSE

doi 10.1308/003588408X261799

CLIVE J KELTY, GREGORY L FALK

Department of Upper GI Surgery, Concord Repatriation General Hospital, Concord, Sydney, New South Wales, Australia

CORRESPONDENCE TO

Clive J Kelty, Department of Upper GI Surgery, Concord Repatriation General Hospital, Concord, Sydney, NSW 2139, Australia
E: clive.kelty@bigfoot.com

We thank Shenfine and colleagues for their comments. However, they have mis-interpreted our argument against the use of prosthetic mesh in repair of hiatal hernias. We agree that mesh is not necessary in primary repair of hiatal hernias, but not that it should be used in the 10–30% of patients who have evidence of recurrence. The majority of patients who have radiological evidence of recurrence are asymptomatic, and re-operation is only advocated in those patients who are either symptomatic, or have a large recurrence with few symptoms but for reasons of perceived risk, such as longevity. We recently reported our own series of 342 massive hiatus hernia repairs without mesh and, despite a radiological recurrence rate of 20% at a median follow-up of 51 months, only 14 patients (4%) required surgery for symptomatic recurrence.¹ We too have had significant problems with mesh-related complications, including one death.

Therefore, we concur with Shenfine and colleagues that repair without mesh is 'not far off good enough'. Mesh repair is a panacea for poor operative technique at the time of primary repair, and this is also indicated by high re-operation rates. Therefore, we would advocate long-term follow-up in this group of patients, reserving re-operation for those with either large recurrences or significant symptoms.

Reference

1. Kelty CJ, Marasovic KM, Martin DJ, Falk GL. Outcome of laparoscopic massive hiatus hernia (MH) repair. Association of Upper Gastrointestinal Surgeons Annual Meeting, Cardiff, September 2007.

COMMENT ON

doi 10.1308/003588407X160783

N Fassiadis, H Zayed, N McDonnell, RE Edmondson. Carotid endarterectomy under local anaesthetic supplemented by an inferior alveolar nerve block. *Ann R Coll Surg Engl* 2007; **89**: 75

doi 10.1308/003588408X261834

Inferior alveolar nerve block

KHALID ABDEL-GALIL

Department of Oral & Maxillofacial Surgery, Leeds Teaching Hospitals, Leeds, UK

CORRESPONDENCE TO

Khalid Abdel-Galil, Specialist Registrar in Oral & Maxillofacial Surgery, Leeds Teaching Hospitals, Clarendon Way, Leeds LS2 9LU, UK
E: khalid.abdel-galil@leeds.ac.uk

I read with interest this technical note on the use of the inferior alveolar nerve block as an adjunct to complement cervical plexus blocks for carotid endarterectomies.

The inferior alveolar nerve block is the most widely used technique for blocking the hemi-mandible. It is routinely used in everyday dental and oral surgical practice and, when combined with infiltration of the lingual and long buccal nerves, it provides adequate anaesthesia of a wide anatomical area. This includes all ipsilateral mandibular teeth and gingivae, body and inferior ramus of the mandible, and anterior two-thirds of the tongue and floor of mouth. However, due to neuro-anatomical and skeletal variations, there is a failure rate of 15–20% in achieving complete anaesthesia. This together with intra-arterial injection and nerve injury are some of the known complications of this mode of anaesthesia.

The authors' technique results in an injection that is higher than the level of the intended target – the mandibular lingula or foramen. This, together with injections that are too low, are common reasons for failure of the technique. To prevent this, the needle of the syringe should be level with the occlusal plane of the mandibular teeth, not above the maxillary occlusal plane, as stated by Fassiadis and colleagues. The expected depth of needle penetration is 20–25 mm.

The technique is facilitated, and made less painful, by the use of a dental cartridge syringe mounted with a 26-G Schimmel needle.