COMMENT ON

doi 10.1308/003588407X168406

MSG Ballal, N Shah, M Ballal, M O'Donoghue, DJ Pegg. The risk of cross-infection when marking surgical patients prior to surgery – review of two types of marking pens. *Ann R Coll Surg Engl* 2007; **89**: 226–8.

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Why not use single-use marker pens?

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I read this article with interest and wonder why there is such a reluctance to move to single-use marker pens? In years to come, I suspect this will seem perverse. If pens can carry an inoculum then they should not be re-used. I know that the skin is intact and areas marked are usually 'prepped' prior to surgery; but the cost of marker pens is trivial and such a move might have the additional benefit of ensuring marker pens are always available.

COMMENT ON

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SJ Srirangam, R Darling, M Stopford, D Neilson. Contemporary practice of percutaneous nephrolithotomy: review of practice in a single region of the UK. *Ann R Coll Surg Engl* 2008; **90**: 40–4

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Percutaneous nephrolithotomy

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This audit of outcome following percutaneous nephrolithotomy (PCNL) in 12 hospitals in 2002 raises some timely questions about contemporary stone management. Cancer services in urology are currently being centralised to major

centres based on the presumption that outcome is improved when surgeons treat large numbers of patients.

Over three-quarters of the patients in this study were treated in non-specialist units; of these departments, 80% were treating fewer than 8 patients per year. Of the patients in this study, 38% had received some other form of unsuccessful therapy for stone disease prior to PCNL and we would argue that patients should not expect such a high failure rate with their primary treatment.

The reported morbidity in this series was also worryingly high, with a 9% failure of access and 8% transfusion rate. In addition, 22% of the patients required a double pigtail ureteric stent, which is extremely uncommon in our practice.

When one considers, also, the steep learning curve associated with training in PCNL and the fact that more than 60 cases are required to achieve competence in the technique,^{1,2} we feel these data clearly demonstrate the need to centralise the management of upper tract stones to units that can offer all forms of treatment with all methods of stone destruction.

Is it now acceptable practice for a urological surgeon to perform small numbers of percutaneous nephrolithotomies?

References

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2. Allen D, O'Brien T, Tiptaft R, Glass J. Defining the learning curve for percutaneous nephrolithotomy. *J Endourol* 2005; **19**: 279–82.

COMMENT ON (Technical section)

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M Jalul, JL McVie. Double-mask technique for shielding the face and eyes during surgical procedures. *Ann R Coll Surg Engl* 2007; **89**: 815–24

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Fogging facemasks

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We agree that it is important to protect the eyes from contamination during surgery. The article states that the double mask technique is cheaper than other options. We have rarely experienced problems with fogging of the visor facemask when worn in the conventional fashion as modern visors have an 'anti-fog' coating. If fogging does occur, a small piece of tape can