Letters and comments

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COMMENT ON

doi 10.1308/003588408X242033

S Sinha, SV Raja, MH Lewis. Recent changes in the management of blunt splenic injury: effect on splenic trauma patients and hospital implications. *Ann R Coll Surg Engl* 2008; **90**: 109–12

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Management of blunt splenic trauma

VASILEIOS TROMPETAS¹, ANDREW SANDISON¹,
HUGH ANDERSON²

Departments of ¹Surgery and ²Radiology, Eastbourne District General Hospital, Eastbourne, UK

CORRESPONDENCE TO

Vasileios Trompetas, Department of Surgery, Eastbourne District General Hospital, King's Drive, Eastbourne BN21 2UD, UK
E: vtrompetas@yahoo.gr

We read this article on the management of blunt splenic injury with interest. Although their experience is rather limited involving 21 cases in 9 years (January 1997 to December 2005), it reflects, to a great extent, the overall practice in the UK. We would like to comment on three points:

1. Non-operative management of splenic trauma also includes splenic artery embolisation. By making a literature search using PubMed and the Cochrane Library, we were unable to identify any reports from the UK of experience on angio-embolisation for splenic trauma. We recently managed successfully, with proximal splenic artery embolisation, an 85-year-old woman with grade III splenic injury and extensive haemoperitoneum after a fall at home. Nevertheless, there is extensive literature on the topic, mostly North American. Arteriography and

embolisation is routinely performed in many trauma centres, and has proved to be a safe and useful investigation and therapeutic intervention.¹ Despite this, there is still much to be said as to its precise role. Embolisation for low-grade injuries is probably unnecessary as these patients may do just as well without it. Patients with higher grade splenic injuries may benefit more as embolisation can result in an increased rate of successful non-operative management. Some reports have questioned the value of indiscretionary embolisation, or have suggested that only specific subgroups of patients may benefit.^{2,3} A multicentre, randomised, controlled trial is necessary to give answers as to which subgroups of non-operative management patients would benefit from embolisation.

2. The reported rarity of blunt splenic trauma is in accordance with the recent report from the Scottish Trauma Audit Group (STAG).⁴ In 2000, STAG retrieved data for the entire Scottish trauma population resulting in an incidence for Scotland of 1.38 per 100,000 population. Many of these were polytrauma patients and about 15% died soon after arrival in hospital from concomitant injuries. If these numbers are extrapolated for the entire UK, it is apparent that a consultant surgeon in a medium-sized district general hospital (DGH) with five surgeons on the general surgical take and serving a population of 300,000 will see on average less than one case per year.
3. The authors have clearly demonstrated that the modern management of these injuries has shifted towards conservative treatment. They concluded that selection of patients for operative versus non-operative management is difficult. This is true, particularly when taking into consideration the limited experience of individual surgeons. Papers originating mostly from North American high-volume trauma centres have described criteria for the non-operative management of blunt splenic injuries.⁵ These are: (i) haemodynamic stability on admission or after initial resuscitation with up to 2 l of crystalloid; (ii) no physical findings or any associated injuries necessitating laparotomy; and (iii) a transfusion requirement attributable to the splenic injury of two units or less.⁵ Even with these criteria, there will still be a small percentage of patients who will fail initial non-operative management and end up having a splenectomy.

The 2007 report of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) focused on trauma

services.⁶ One of its recommendations was the designation of level I trauma centres in the UK. Although this may improve the outcome of severely multiple injured patients, we still feel that patients with isolated or predominantly splenic injury can be safely managed in a DGH provided that general surgical, anaesthetical, intensive care and CT scan services are available on demand, as well as an interventional radiologist during working hours.

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COMMENT ON

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N Coull, H Mastoroudes, R Popert, TS O'Brien. Redefining urological history taking – anal intercourse as the cause of unexplained symptoms in heterosexuals. *Ann R Coll Surg Engl* 2008; **90**: 403–5

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Urological history taking

RASHEED AHMAD, ATIF KHALIL
Consulting Rooms, 'Shalamar', Woolton Park, Liverpool, UK

CORRESPONDENCE TO

Rasheed Ahmad, Consulting Rooms, 'Shalamar', Woolton Park, Liverpool L25 6DU, UK
E: theahmads@aol.com; W: www.rasheedahmad.co.uk

In patients suspected of a urinary tract infection, it is a mandatory requirement to take, in detail, the sexual history. Coull and colleagues describe their 9 cases with symptoms of urinary tract infection following anal intercourse in heterosexuals practising unprotected sex. However, it was interesting to note that all, including the three who had not received antibiotics, did get better. Again, all but another three had undergone an ultrasound examination but the staging and indication of this investigation was not made clear. Further, the authors in their discussion recommended the use of condoms in anal intercourse but only recommended this practice to three of their 9 patients. Finally, we must remind the authors that the practice of

vaginal intercourse outside marriage is not only forbidden in some cultures but also in all Abrahamic religions.

AUTHORS' RESPONSE

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NADINE COULL, TIM O'BRIEN
Department of Urology, Guy's Hospital, London, UK

CORRESPONDENCE TO

Nadine Coull, Department of Urology, Guy's Hospital, London, UK
E: nquatan@hotmail.com

We thank Ahmad and Khalil for their comments on our clinical vignette. Broadly speaking, the urinary tract ultrasound was usually combined with a flow study and was used to exclude a range of urogenital complaints including incomplete bladder emptying, bladder stones, stricture disease, localised testicular infection or tumour.

Urinary infections sometime improve without antibiotics as any woman who has had bacterial cystitis will attest. All patients were advised that unprotected anal intercourse was probably contributing to their symptoms, and it is unsurprising that the symptomatology of these patients improved without recourse to the use of antibiotics. The use of condoms was especially recommended to the patients who did not wish to discontinue the practice altogether.

The 'reminder' about the sexual practices considered acceptable by various religions is unnecessary – we merely report on the patients we had an opportunity to help.

COMMENT ON

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L Corfield, A Schizas, A Williams, A Noorani. Non-attendance at the colorectal clinic: a prospective audit. *Ann R Coll Surg Engl* 2008; **90**: 377–80

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'Lean' out-patient clinics

HP PRIYANTHA SIRIWARDANA, GORDON N BUCHANAN
Colorectal Unit, Department of GI Surgery, Charing Cross Hospital, London, UK

CORRESPONDENCE TO

HP Priyantha Siriwardana, Colorectal Unit, Department of GI Surgery, Charing Cross Hospital, Fulham Palace Road, London W6 8RF, UK
E: hppsir@hotmail.com

We would like to congratulate Corfield and colleagues for their recent audit on colorectal clinic non-attendance,