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.

References

1. Haan JM, Biffl W, Knudson MM, Davis KA, Oka T, Majercik S *et al.* Splenic embolization revisited: a multicenter review. *J Trauma* 2004; **56**: 542–7.
2. Harbrecht BG, Ko SH, Watson GA, Forsythe RM, Rosengart MR, Peitzman AB. Angiography for blunt splenic trauma does not improve the success rate of non-operative management. *J Trauma* 2007; **63**: 44–9.
3. Wu SC, Chow KC, Lee KH, Tung CC, Yang AD, Lo CJ. Early selective angioembolization improves success of nonoperative management of blunt splenic injury. *Am Surg* 2007; **73**: 897–902.
4. Brady RR, Bandari M, Kerssens JJ, Paterson-Brown S, Parks RW. Splenic trauma in Scotland: demographics and outcomes. *World J Surg* 2007; **31**: 2111–6.
5. Meguid AA, Bair HA, Howells GA, Bendick PJ, Kerr HH, Villalba MR. Prospective evaluation of criteria for the nonoperative management of blunt splenic trauma. *Am Surg* 2003; **69**: 238–42, discussion 42–3.
6. Findlay G, Martin IC, Carter S, Smith N, Weyman D, Mason M. *Trauma: Who cares?* London: National Confidential Enquiry into Patient Outcome and Death, 2007.

COMMENT ON

doi 10.1308/003588408X301000

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

doi 10.1308/003588409X391983

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

doi 10.1308/003588409X391974

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

doi 10.1308/003588408X301172

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

doi 10.1308/003588409X391992

'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,

which not only wastes resources but frustrates staff.^{1,2} However, although the authors suggest that the weather makes no difference in 'did not attend' rate, re-analysis of their raw data shows a highly significant linear trend for worsening attendance with improving weather conditions (13.3% 'did not attend' on raining days versus 30.7% on hot sunny days; $P = 0.033$, chi-squared test for trend).

The other factor that we could not glean from the data was whether positive response to a telephone call influenced 'did not attend' rates; *i.e.* if the 'did not attend' rate was less in those who responded to a telephone call than those who did not, then this would imply that contact with a patient to confirm a booking (like in a restaurant) was actually useful.

Similarly, we have been frustrated by 'did not attend' on the day of surgery, and to reduce this we are taking patients off the scheduled operating list for routine surgery if they have not confirmed their intention to attend in advance – this so-called 'lean theatre' has helped to reduce 'did not attend' for surgery in Charing Cross Hospital, and a similar 'lean clinic' approach might be employed to reduce non-attendance at clinics.

References

1. Hull AM, Alexander DA, Morrison F, McKinnon FS. A waste of time: non-attendance at out-patient clinics in a Scottish NHS Trust. *Health Bull (Edinb)* 2002; **60**: 62–9.
2. Pal B, Taberner DA, Readman LP, Jones P. Why do outpatients fail to keep their clinic appointments? Results from a survey and recommended remedial actions. *Int J Clin Pract* 1998; **52**: 436–7.

AUTHORS' RESPONSE

doi 10.1308/003588409X392009

LORRAINE CORFIELD, ALEXIS SHIZAS, ANDREW WILLIAMS
Department of Colorectal Surgery, St Thomas' Hospital, London, UK

CORRESPONDENCE TO

Lorraine Corfield, Department of Colorectal Surgery, St Thomas' Hospital, London, UK. E: icorfield@doctors.org.uk

We thank Siriwardana and Buchanan for their insightful response to our paper and particularly the re-analysis of the effect of weather on 'did not attend' rate. The telephone calls did not influence 'did not attend' rates in that the overall rate did not improve significantly after attempted telephone reminders. We did not record the 'did not attend' rate in the group who were successfully contacted by telephone but the fact remains that attempted calls (the equivalent of 'intention to treat') were ineffective in reducing 'did not attend' rate.

The suggested 'lean clinic' approach is an interesting proposition and worth considering. We have some reservations that, due to the difficulty encountered by some patients

in our study (9.5%) in successfully contacting the hospital, current systems will not allow for the smooth running of such a service. Patients may also arrive on their appointment day without having confirmed which then creates the dilemma as to whether to see these patients, particularly as notes will not be available.

COMMENT ON

doi 10.1308/003588408X301109

MK Nasr, JS Budd, M Horrocks. Uncomplicated varicose vein surgery in the UK – a postcode lottery. *Ann R Coll Surg Engl* 2008; **90**: 474–6.

doi 10.1308/003588409X392027

Rationing of treatment for varicose veins

BRUCE CAMPBELL

Department of Vascular Surgery, Royal Devon and Exeter Hospital, Exeter, UK

CORRESPONDENCE TO

Bruce Campbell, Consultant Vascular Surgeon, Royal Devon and Exeter Hospital, Exeter EX2 5DW, UK
E: bruce.campbell@nice.org.uk

Nasr, Budd and Horrocks will each be embarrassed to learn that their knowledge and search of the literature failed to register our larger, roughly contemporaneous and arguably more successful survey on rationing of treatments for varicose veins.¹ They make more than one claim for originality of their work: I will leave it to others to challenge the 'first published email survey in vascular surgery' and concentrate on the aspect of rationing of varicose vein treatments ('There has been no survey to date').

I have no pique about them missing our publication: it provides a wonderful opportunity to snipe at friends and some comparisons of their survey with ours are interesting. The numbers of surgeons included (from the same pool) were 245 and 411 and the response rates were 44% and 75%, respectively. Based on these observations, one could conclude that:

1. An email survey allows inclusion of a substantially smaller number of people from the same professional group.
2. The response rate to an email survey is grossly less than a postal survey.
3. Publishing a paper in the electronic part of a journal, rather than in full in the paper copy (*i.e.* our paper in the *Eur J Vasc Endovasc Surg*) makes it easy to miss.

Re-assuringly, the main findings of Nasr and colleagues from the 109 surgeons who responded to them about rationing of varicose vein treatments were similar to those from the 307 whose responses we published.