are alternatives to remaining an in-patient for surgery on an emergency list. For example, these patients can be discharged home once their symptoms have settled, with a date for a laparoscopic cholecystectomy within a month, on a dedicated (potentially day-case) 'hot gallbladder' list.

COMMENT ON

doi 10.1308/003588408X261627

A Rafee, D Herlikar, R Gilbert, RC Stockwell, GJ McLauchlan. D-Dimer in the diagnosis of deep vein thrombosis following total hip and knee replacement: a prospective study. *Ann R Coll Surg Engl* 2008; **90**: 123–6

doi 10.1308/003588409X428324

Another nail in the coffin for role of D-dimer in diagnosis of postoperative deep vein thrombosis!

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The authors must be commended on their elaborate effort to prove the futility of D-dimer testing in postoperative patients. Innumerable studies have been done to try and prove the usefulness of D-dimer testing along with pre-test probability score, all aimed at avoiding expensive imaging.^{1–3} The study could have been more meaningful if they had clarified the following issues:

1. The specificity and sensitivity of D-dimer levels vary with the type of test—enzyme-linked immunofluorescence assay (ELFA), microplate enzyme-linked immunosorbent assay (ELISA) or latex quantitative assay; the authors have not mentioned which test type did they use.⁴
2. In the historical controls, only 37% patients had deep vein thrombosis (DVT) on or before day 7 after joint replacement surgery. The assessment of D-dimers pre-operatively and on postoperative days 1, 3, 5, 7 and duplex imaging on day 7 would have missed out a major proportion of patients likely to develop DVT (up to 63%). Considering the fact that the authors first presented this work in 2005, follow-up data on these 78 patients, if available, could have made the present publication more meaningful.
3. The value of day 1 D-dimer in the published abstracts^{5,6} of their presentations is 3.63 compared to 3.39 in the present article, without any obvious change in any other numbers, probably a typing error in the present article.

D-Dimer should remain as a screening test for proximal DVT and pulmonary embolism for out-patients with low clinical probability of DVT, where it obviates the need for a duplex ultrasound examination. Positive D-dimer, irrespective of its value, has little meaning when the probability of clinical DVT is high.

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COMMENT ON

doi 10.1308/003588408X318138

WD Beasley, CP Gibbons. Cranial nerve injuries and the retrojugular approach in carotid endarterectomy. *Ann R Coll Surg Engl* 2008; **90**: 685–8

doi 10.1308/003588409X428432

Points for clarification

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I read this paper with interest and congratulate the operating surgeon on his low cranial nerve injury rates. I would be grateful for clarification regarding the following issues. Why were there 225 exclusions? Did the cranial nerve injuries occur early in the series or late and were they the reason for the stated change in approach? What is meant by 'targeted follow-up' and how long did the injuries take to resolve (*i.e.* was this a reflection of the effect of local anaesthetic infiltration or tension neuropraxia)? Why was the chi-squared test used for such small numbers of complications?

First, the Fisher's exact test might have been more appropriate, and second there is the risk of confusing clinically significant differences with statistically significant differences. This is relevant in the consideration of haematoma (no statistically significant difference in proportions). Were the necks re-explored (a clinically significant outcome not commented upon) and, if so, was there a clear cause for the haematoma that would differ between the groups (*e.g.* a slipped ligature on the facial vein)?

I agree with the conclusion that a much larger series would be needed to evaluate fully the difference in rates of nerve injury complications, but would suggest that a better conclusion would be that, in experienced hands, local anaesthetic carotid endarterectomy has a very low rate of permanent cranial nerve injury irrespective of approach.

AUTHORS' RESPONSE

doi 10.1308/003588409X428441

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In response to the points raised:

1. The study compared the incidence and type of cranial nerve injuries in patients undergoing carotid endarterectomy using the retrojugular and antejugular approaches. During the early phase of the 16 years recorded in the database, all patients were operated on using the antejugular approach and a standard arteriotomy under general anaesthetic. To avoid the considerable heterogeneity that would have been introduced by the inclusion of these cases, we confined our analysis to those patients undergoing eversion endarterectomy under local anaesthetic, as we clearly stated in the paper.
2. The cranial nerve injuries were distributed evenly throughout the series.
3. By 'targeted follow-up' we mean that those cases complicated by cranial nerve injury had more intense postoperative surveillance in order to observe the cranial nerve injury specifically.
4. Cranial nerve injuries were recorded after 24 h and were thus well after the local anaesthetic had worn off. The precise duration of each cranial nerve lesion was not recorded but most persisted for a period of weeks after surgery.
5. We accept that Fisher's exact test could have been used as there are small expected frequencies; however, the P-values derived do not reach statistical significance (Table 1).

Table 1 Retrojugular versus antejugular carotid endarterectomy complications

Complication	Exact <i>P</i> -value
Major complications	
Death	1
Myocardial infarction	1
Permanent central neurological deficit	1
Transient central neurological deficit	1
Haematoma	0.25
Cranial nerve injuries	
VII	1
X	1
XI	0.06
XII	0.68
Total	0.14

6. Haematomata were recorded as clinically significant if they required re-exploration. A precise bleeding point was rarely identified in these cases. Over the last 5 years, re-exploration for bleeding has been almost totally eliminated by applying manual pressure to the wound for 20 min after closure and ensuring that the patient is sitting upright in the recovery room.

Because of the relatively small incidence of cranial nerve injury in carotid endarterectomy, large numbers would be required to show any difference between the two approaches. Our study suggests that the incidences are of similar magnitudes but that the more posterior dissection may put the accessory nerve at greater risk.

COMMENT ON

doi 10.1308/003588408X321774

I Goutos, MCJ Button, AA Brown. A novel technique to facilitate the use of circular staplers in anterior resections and reversal of Hartmann's procedures. *Ann R Coll Surg Engl* 2008; **90**: 698

doi 10.1308/003588409X428450

Reservations

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We appreciate the novel technique which Goutos and co-