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

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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

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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

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Reservations

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We appreciate the novel technique which Goutos and co-