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

WD BEASLEY, CP GIBBONS

Department of Vascular Surgery, Morriston Hospital, Swansea, UK

CORRESPONDENCE TO

William D Beasley, Department of Vascular Surgery, Morriston Hospital, Swansea SA2 7NW, UK
E: williamdbeasley@hotmail.com

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

ISMAIL H MALLICK, NAJAF N SIDDIQI, GEETINDER KAUR
Department of Colorectal Surgery, Scunthorpe General Hospital, Scunthorpe, UK

CORRESPONDENCE TO

Ismail H. Mallick, Department of Colorectal Surgery, Scunthorpe General Hospital, Scunthorpe, UK
E: docmallick@googlemail.com

We appreciate the novel technique which Goutos and co-

workers have used in performing the colorectal anastomosis using the circular stapler. However, we have some reservations about the technique.

How it is possible to detach the ice cube from the rectum when it was cross-stapled proximally? They have also mentioned that melting the hard ice cube is aided by body temperature – does this not increase the procedure time?

Did the authors bear in mind the effect of sub-zero temperatures in the area of the colorectal anastomoses? What were the effects of freezing and thawing on the rectal mucosa? The authors also claim to have performed this novel technique in 20 resections; it would be useful to know how many had defunctioning stomas.

We feel that the described technique is cumbersome and difficult to use; it adds extra time to the procedure and its effects on anastomotic healing have not been studied.

AUTHORS' RESPONSE

doi 10.1308/003588409X428469

IOANNIS GOUTOS, MATTHEW CJ BUTTON, ASHLEY A BROWN
Department of Surgery, Southend University Hospital, Westcliffe-on-Sea, Essex, UK

CORRESPONDENCE TO

Ioannis Goutos, ST3 Plastic Surgery, Oxford Deanery, Stoke Mandeville Hospital, Mandeville Road, Bucks HP21 8AL, UK
E: ioannisgoutos@hotmail.com

In response to the reservations expressed by Mallick and colleagues regarding our novel technique to facilitate the use of circular staplers in colorectal anastomoses, we would like to clarify the following points:

1. The detachment of the ice cube from the stapling device is carried out through the abdomen by the operating surgeon pushing the ice cap off from outside the rectum and is aided by the rapid melting at body temperature as well as the slow advancement of the stapler anvil. The ice tip simply falls out of the shallow cup made by the end of the stapler. We have not noted an increase in the duration of any of the operations in which this technique was tested.
2. Of the patients who underwent reversal of Hartmann's procedures, none required defunctioning stomas.
3. Regarding the effect of low temperatures on the rectal mucosa, we believe the localised exposure of the bowel wall to sub-physiological temperatures is so short that it is extremely unlikely to result in physiological compromise in the perianastomotic region. In addition, it is common knowledge that the amount of heat required to melt ice (latent heat of fusion) is 80 calories (336 kJ) per gram.¹ The ice cube in our method has a weight of 10 g thus requiring 800 calories (3360 kJ) of energy. Cooling of a litre of water by 1°C will

provide 1000 calories (4200 kJ).² The temperature drop associated with ice melting is negligible taking into account blood flow, the surgeon's hand and the considerable larger mass of pelvic organs available for energy dissipation.

We believe that our technique of performing bowel anastomoses using circular staplers represents a technically easy and safe modification for the long rectal stump in which the flat end of the stapler is liable to 'catch' in the circular folds.

References

1. Weast RC. (ed) *CRC Handbook of Chemistry and Physics*, 81st edn. Cleveland, OH: CRC Press, 2000.
2. <<http://www.science.uwaterloo.ca/~cchieh/cact/nuctek/energyheat.html>>.

COMMENT ON

doi 10.1308/003588408X318110

JK Smith, AG Acheson, JAD Simpson, J Stewart, IJ Beekingham, CB Gornall, JP Williams *et al.* From small acorns – developing a laparoscopic colorectal service. *Ann R Coll Surg Engl* 2008; **90**: 606–11

doi 10.1308/003588409X428478

Learning curve in laparoscopy and registrar training

IAN FLINDALL
Addlestone, Surrey UK

CORRESPONDENCE TO

Ian Flindall, Selbourne Avenue, New Haw, Addlestone, Surrey KT15 3RD, UK. E: ianfindall@hotmail.com

The article by Smith and colleagues rightly emphasises the learning curve in laparoscopic colorectal surgery. The department undertook a safe and step-wise approach to laparoscopic implementation. In this article, it took over 3 years before the consultants felt sufficiently experienced for a trainee to perform the procedure. As more departments opt for performing laparoscopic surgery, a similar process will be followed.

It must be recognised that this time period is going to have a significant impact on registrar training. It is the current group of registrars who will experience this effect, yet the expectations regarding what operations they are to perform has remained unchanged. Trainees are becoming very concerned that they will be criticised for being unable to manage bowel resections. Either, sub-specialisation needs to be properly implemented nation-wide on the on-call rota (thus reducing the number of trainees required to do extensive bowel resection) or training length is going to need to be increased. Surgical procedures are advancing, but there is fast becoming a void between trainee and consultant. The College needs to recognise this and assist the deaneries in bridging this gap.