or emergency surgery to decompress the cauda equina prior to the onset of CESR. There is on-going debate as to whether that surgery should be carried out as an emergency, out-of-hours, or on the next day-time list.

4. If, at the point of first assessment, the patient has bladder paralysis (CESR), the decision (as to whether urgent or emergency MRI and/or surgery is required) depends upon the surgeon's assessment of the medical literature. If the surgeon takes the view that there is no benefit to urgent decompression following bladder paralysis, there is no urgency for diagnosis and treatment. However, the fact that there is uncertainty in this area and the fact that some studies have suggested a window of opportunity extending to 24 h (or possibly 48 h) after the onset of CESR, suggests that perhaps the precautionary principle should be adopted and patients should be decompressed urgently on the basis that there is scientific uncertainty. Whether such patients should be operated out-of-hours as a true emergency is also a matter of debate.

I do hope that this clinical algorithm adds strength to the conclusions set out by Crocker and colleagues. I agree that many patients can appropriately have imaging performed promptly within the DGH but it is important that we have a selective approach to: (i) patients who should be initially managed at the DGH; (ii) patients who require urgent or emergency MRI; and (iii) patients who require urgent or emergency treatment.

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AUTHORS' RESPONSE

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We are grateful to Todd for his comments and observations.

He specifically asks about the numbers of patients in the two groups and the overlap, group 1 being patients undergoing emergency MRI for suspected cauda equina syndrome and group 2 being patients having emergency discectomy for clinically and radiologically confirmed cauda equina syndrome. The confusion perhaps relates to ambiguity over the term 'emergency'. We have studied group 1 as defined as patients having MRI out of normal working hours for suspected cauda equina syndrome, hence an emergency group. This will, however, miss a small number of patients from the local area who underwent an emergency MRI for suspected cauda equina syndrome during working hours using our own MRI scanner. The second group of patients we have defined as those undergoing unscheduled (*i.e.* not admitted electively) discectomy for cauda equina syndrome, some being done during normal working hours. True, 27 of the 82 patients having emergency (out-of-hours) MRI proceeded to surgery, but in only 5 of these 27 was the clinical and radiological correlate sufficient to warrant direct procession to surgery that night, hence a true 'emergency' case of cauda equina syndrome. This represents a difficulty of this retrospective study but, moreover, a difficulty which confounds much of the literature: specifically what does constitute the cauda equina syndrome? Certainly, the combination of perineal sensory loss, painless urinary retention and/or incontinence with unilateral or bilateral L5 or S1 symptoms as a consequence of compressive pathology in the spinal canal, typically a large disc prolapse, will qualify. However, the less clearly defined group of incomplete cauda equina syndrome patients are defined differently by different commentators.

The work presented represents a documentation of current practice and allows the assessing clinician and the on-call spinal service to understand what index of suspicion should be maintained for true cauda equina syndrome in this group of patients, prior to interhospital transfer for on-call MRI. It is strengthened by reading alongside the contemporary study by Bell *et al.*,¹ who found positive predictive values for a large central disc of around 0.6 for each of urinary retention, urinary frequency, urinary incontinence, altered urinary sensation and altered perineal sensation. Todd's proposed algorithm for attempting to identify the most urgent cauda equina syndrome patients from those who may reasonably be imaged the next day is a good proposition and it would be interesting to see it applied hypothetically to a cohort of well-documented patient episodes to test its strengths and weaknesses.

We agree that the timing of surgery is a matter of debate; we also agree, however, that, given the good outcomes seen following expeditious surgery for incomplete cauda equina syndrome, to treat this as a non-emergency matter falls foul not only of the somewhat weak published evidence but, more seriously, of medical and scientific common sense. We

agree that it is appropriate to offer such emergency treatment to patients with complete cauda equina syndrome, especially given that long delays from the onset of bladder paralysis from cauda equina syndrome are fortunately uncommon. The issue of surgery as an emergency is indeed controversial; however, if a large central disc prolapse is suspected to be causing impending or true bladder disturbance, the risk–benefit analysis, even in the absence of good quality evidence, surely falls strongly in favour of decompressive surgery. A further confounding factor in this situation is the use of unreliable outcome measures that are highly specific to the individual: arguably, a bilateral foot drop will be a greater inconvenience to some patients than loss of sexual function or the requirement to use a catheter. The difficulties of outcome assessment have been discussed previously and are likely to continue.²

There is unlikely to be good quality prospective scientific evidence in this area given the impossibility of developing a realistic and predictable animal model of disc prolapse, and equally given the inappropriateness of subjecting patients with such a critical condition to a trial of delayed versus immediate surgery. Hence, the modern literature is likely to be confined to observational studies with the opinions of experienced clinicians.

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COMMENT ON

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R Kennedy, I Jenkins, P Finan. Splenic flexure mobilisation for anterior resection performed for sigmoid and rectal cancer. *Ann R Coll Surg Engl* 2008; **90**: 638–42

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Support for the selective approach to splenic flexure mobilisation

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I have read with interest the argument for and against routine mobilisation of the splenic flexure in anterior resection

for cancer. In our practice, the decision to mobilise the splenic flexure for left colonic or anterior resections is made easy; most of our patients (females more than males) have redundant left and sigmoid colons and the incidence of diverticular disease is rare. After division of the inferior mesenteric artery just distal to the left colic artery, the colon can be brought down to the pelvis without tension or compromised vascularity. Only on some rare occasions was the mobilisation deemed necessary to avoid tension at the anastomotic site. What was used to be practiced in open surgery is now translated even more precisely and efficiently during laparoscopic colonic resection. Based on this, I totally support (at least in our population) the selective approach to splenic flexure mobilisation which was advocated and argued for by Kennedy and Jenkins.

In my modest experience with 25 left hemicolectomies and anterior resections that were performed either laparoscopically ($n = 10$) or hand-assisted ($n = 15$), none needed formal mobilisation of the splenic flexure. Moreover, there were no conversions and neither anastomotic leaks nor strictures.

AUTHORS' RESPONSE

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We are re-assured by Meshikhes' supportive response defining experience gained with selective splenic flexure mobilisation in King Fahad Specialist Hospital. The principle has been applied successfully in the laparoscopic arena. We are encouraged that there have been no conversions or anastomotic leaks with no requirement for flexure mobilisation.

In our experience, splenic flexure mobilisation will usually be required to ensure adequate length during total mesorectal excision (TME); however, Meshikhes' experience adds to the expanding literature indicating that most other rectal and sigmoid resections will not require such extensive dissection. This has important implications with the increasing adoption of laparoscopic techniques in the management of colorectal disease.