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.

References

1. Bell DA, Collie D, Statham PF. Cauda equina syndrome: what is the correlation between clinical assessment and MRI scanning? *Br J Neurosurg* 2007; **21**: 201–3.
2. Hussain SA, Gullan RW, Chitnavis BP. Cauda equina syndrome: outcome and implications for management. *Br J Neurosurg* 2003; **17**: 164–7.

COMMENT ON

doi 10.1308/003588408X358774

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

doi 10.1308/003588409X428504

Support for the selective approach to splenic flexure mobilisation

ABDUL-WAHED NASIR MESHIKHES

Department of Surgery, King Fahad Specialist Hospital, Dammam, Saudi Arabia

CORRESPONDENCE TO

Abdul-Wahed Nasir Meshikhes, Department of Surgery, King Fahad Specialist Hospital, Dammam 31444, Saudi Arabia
E: meshikhes@gmail.com

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

doi 10.1308/003588409X428513

IAN JENKINS, ROBIN KENNEDY

St Mark's Hospital, Harrow, Middlesex, UK

CORRESPONDENCE TO

Ian Jenkins, St Mark's Hospital, Harrow, Middlesex HA1 3UJ, UK
E: mrianjenkins@aol.com

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.