and patients who have waited to see a physician, been sent for nerve conduction studies and then referred to me can be already approaching 18 weeks from their original GP referral.

I do not know the take-up rate for patients selected by me as suitable for the clinic, but my impression is that it is high. The mean age of those attending was 52 years (range, 30–80 years), so many of the patients would be in employment.

The arrangements for the clinic are that I see the first patient at 1.30 in the pre-assessment clinic area, with no other clinics being cut to accommodate it. The first patient is taken to theatre at 2.00 and a registrar performs the operation. The subsequent patients are operated on by me or a registrar or SHO under my supervision, and we have found the clinic very useful for teaching junior surgeons to perform carpal tunnel decompression.

In the weeks when I am not doing the one-stop clinic, I would either be doing an out-patient clinic or have no NHS commitments, and the theatre is used for a staff grade day-case list, so I do not believe there are any hidden costs, and would encourage Mr Clay to set up a similar clinic.

COMMENT ON

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SJW Monkhouse, JDT Morgan, SA Norton. Complications of bariatric surgery: presentation and emergency management – a review. *Ann R Coll Surg Engl* 2009; **91**: 280–6

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A plethora of gastric bands

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I would like to raise one issue. The statement ‘all surgeons should familiarise themselves with the locking mechanisms of the common bands in use so that emergency removal can be facilitated’ is preposterous.

There are several gastric bands commonly used and new variants are being introduced each year. Many have different locking mechanisms and most are difficult to unlock laparoscopically without considerable practice. I believe such surgery is outside the scope of most non-specialist surgeons and, if attempted, could result in gastric perforation especially with a compromised stomach. In an emergency, open rather than laparoscopic removal of the band may be the safer option if referral to a bariatric surgery centre is not feasible.

The NHS and most PCTs have failed to meet the demand for bariatric surgery in this country. As a consequence, an ever increasing number of patients elect to use the private sector, often abroad, for their initial surgery but rely on NHS facilities for the management of any subsequent emergency complications. The inappropriate management of these by non-specialist units has resulted in mortality. Rather than expecting ‘all surgeons’ to be familiar with detailed aspects of gastric bands, it would be far better for all hospitals in the UK accepting general surgical emergencies to have at least two experienced surgeons specifically trained to deal with bariatric emergencies.

This, I fear, will not be realised in my surgical life-time.

AUTHOR'S COMMENT

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We agree wholeheartedly with the concerns regarding inadequate NHS provision of bariatric surgery that encourages patients to seek treatment abroad. We, like many bariatric units, are seeing an increasing number of patients left with poor follow-up after such surgery leaving them vulnerable to complications. The purpose of this review was to help the non-specialist in the recognition of these complications, to understand when urgent management is needed and to refer to a specialist unit where appropriate. Unfortunately, delay in surgery whilst specialist bariatric opinions are sought has resulted in avoidable gastric ischaemia and we feel that emergency gastrointestinal surgeons should be able to remove a gastric band if required. If they are not comfortable doing this by the laparoscopic approach then, of course, open surgery is indicated. However, knowledge of the locking mechanism of common bands may avoid the added morbidity of open surgery in a patient who may still be significantly overweight.

As the number of such patients continues to rise, every hospital managing general surgical emergencies, whether a bariatric unit or not, urgently needs to address the problem of morbid obesity. This will not just need appropriately trained surgeons but anaesthetists *etc.* too – and vital equipment including large CT scanners, stronger operating tables and hoists will all be required to deal with this increasingly common problem.