Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. Tables and figures should only be included if absolutely essential and no more than five references should be given. The editor reserves the right to shorten letters and subedit contributions to ensure clarity.

COMMENT ON

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R Farouk, R Bhardwaj, RK Phillips. Stapled transanal resection of the rectum (STARR) for the obstructed defaecation syndrome. *Ann R Coll Surg Engl* 2009; **91**: 287–91

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Stapled transanal resection of the rectum (STARR) for obstructed defaecation syndrome

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We read with interest the recent debate about STARR for obstructed defaecation syndrome. However, we disagree with several of the points made by Bhardwaj and Phillips.

They start their argument with the issue of ‘abnormalities’ found on proctography of normal volunteers and quote the small proctographic study by Shorvon *et al.*¹ of normal volunteers which analysed 25 men and 21 women. It is misleading to say that this study showed a rectocele in 80% of asymptomatic women, as the rectocele depth exceeded 2 cm (the upper limit of normal for most radiologists) in only one patient of the 46 studied. On the seven point grading of intussusception used in this study, 55% did have intussusception but in only 18% was this high grade (impinging on the anal

canal). A more recent proctographic study of normal volunteers has shown that, whilst intussusception may be seen in asymptomatic patients, this is significantly less advanced and tends to be mucosal when compared to symptomatic patients.² The relevance of proctographic studies in asymptomatic patients is in any case dubious; we do not see these patients in our pelvic floor clinics.

We would argue that in many (but certainly not all) cases of obstructed defaecation, there is a relevant structural abnormality. The overlap of symptomatic and asymptomatic patients when studied proctographically does not necessarily contradict this but perhaps reflects the fact that proctography is an imperfect test. Some patients may need an examination under anaesthetic to aid their diagnosis and treatment.

Bhardwaj and Phillips compare operating on obstructed defaecation syndrome patients to operating on patients with hypertension or asthma. Hypertension and asthma are well treated pharmacologically but are not amenable to surgery. By contrast, obstructed defaecation syndrome patients may be controlled by biofeedback and pharmacological manipulation, but many will not respond to these measures and move on to surgery.

The issue of whether surgery is effective becomes the second major issue of the debate. We were disappointed that Bhardwaj and Phillips quote three papers that were each almost 20 years old as evidence that rectopexy does not cure obstructed defaecation syndrome.^{3–5} All three papers were reporting an open surgical technique that included a full posterior rectal mobilisation. This mobilisation would have caused rectal denervation affecting defaecatory function and continence.^{6–8} In our own experience of 75 patients treated for intussusception/obstructed defaecation syndrome by laparoscopic ventral mesh rectopexy, there was no major morbidity and a median hospital stay of 2 days. Overall, 86% reported an improvement in obstructed defaecation syndrome symptoms and 85% an improvement in continence.⁹

Finally, in support of biofeedback, Bhardwaj and Phillips quote a single retrospective study¹⁰ of 34 patients before saying that the ‘evidence is poor’ for treating obstructed defaecation syndrome with STARR. We believe that surgery remains an option for patients who fail non-surgical treatments.

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COMMENT ON

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MJ Reid, LA David, JE Nicholl. A one-stop carpal tunnel clinic. *Ann R Coll Surg Engl* 2009; **91**: 301–4

Lack of cost analysis

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Although this study highlights improvements in speed of treatment delivery, the suggested benefits of cost-reduction had no costing data at all. There were no comments on additional costs, such as time to review referral letters, send out Boston questionnaires and book them into the one-stop clinic. I assume that the clinical assessment of the patients taking approximately 1 h would mean that the allocated operating theatre would be empty and unused for this time, hence under-using theatre time resources. The nursing and

clinic costs for monitoring the patients pre- and postoperatively may be less than a day-surgery bed but no costs are given. A presumption is made that the surgeon routinely arranges wound care follow-up with the general practitioner but, again, this is not clear. It is obviously beneficial to have treatment as soon as practicable but I think proper cost-analysis would have added weight to this study.

AUTHORS' RESPONSE

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Although a full cost-analysis was not detailed in this paper, there are cost savings to both patient and trust without the concern of additional expenditure that Middleton has raised.

Review of the referral letters is undertaken in the usual manner and patients with suspected carpal tunnel syndrome are sent an information sheet and telephoned by the secretary, who explains what is involved and their likely recovery if surgery is performed. Patients are then given an appointment at a one-stop clinic or a routine appointment if they decline this service. We do not perceive any appreciable cost in this process.

The arrangements for the clinic are that the first patient is seen at 1.30 pm 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 pm 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. There is, therefore, no under utilisation of theatres. Additionally, 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.

As is detailed in the paper, follow-up is arranged with the general practitioner for removal of sutures and wound care. This, in addition to the fact that they only have to attend the hospital once, will reduce the costs to the patient in terms of transportation and lost work days.

We would encourage others to set up a similar clinic.