noted the increasing enthusiasm for diagnostic laparoscopy in recent years amongst our colleagues. In a similar fashion to the authors, in clear-cut cases of appendicitis on initial presentation we leave the surgical approach (open or laparoscopic) to the discretion of the operating surgeon, but as a consultant firm we have generally employed the 'active observation'¹ approach (without computerised tomography) for the management of patients with suspected appendicitis with equivocal signs and symptoms, rather than performing diagnostic laparoscopy.

Aware of our traditional approach in the face of the increasing use of diagnostic laparoscopy, we conducted a 9-month retrospective audit of patients admitted with suspected appendicitis under the care of the lead author (DJA) to assess our outcomes. In total, 38 patients underwent appendectomy, performed via both open and laparoscopic approaches, resulting in a 5% negative appendectomy rate (two patients). No additional or alternative diagnoses were made at the time of surgery, and no patients discharged with a diagnosis of non-specific abdominal pain were re-admitted with appendicitis. Bearing in mind reported re-admission rates of 33% in patients undergoing a negative appendectomy,² as well as the small but real risks of diagnostic laparoscopy, such as major vascular injury or significant port-site bleeding,³ we are happy to continue our approach to managing patients with suspected appendicitis without laparoscopy used solely as a diagnostic tool.

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A gold standard technique!

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COMMENT ON

Banerjee A, Bhargava AM. The case for laparoscopic incisional hernia repair. *Ann R Coll Surg Engl* 2009; **91**: 631–6

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To make the laparoscopic approach a gold standard for incisional hernia repair it would be helpful to adopt a 'single

classification' such as was produced recently by the European Hernia Society.¹ Furthermore, developing a 'national incisional hernia register' would enable good quality data collection. These changes would clarify the heterogeneity that exists in the current literature and would allow a fair assessment of the safety and effectiveness of operative approaches.² Until that time, there remains a place for both.

It would have been appreciated if the authors had quoted a UK-based cost analysis, if there is any. It would be of interest to know whether there should be differences in the tariff and codes in the NHS and private sector for the repair of incisional hernias of different sizes. We all know that to repair a 15 cm defect is not the same as for a 5 cm defect, irrespective of the approach used.

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Is it ever really necessary to use an anchor?

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COMMENT ON

Al-Khateeb H, Goldie B. A novel technique for humeral head retrieval. *Ann R Coll Surg Engl* 2009; **91**: 517

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We read with interest the authors' method of humeral head retrieval during replacement surgery for a 3 or 4 part fracture of the proximal humerus. Normally we have found the innovations described in the techniques section of the journal most useful; in fact we have adopted a number of the published techniques in our own practice over the years. In our experience, the published techniques are innovative and, for the most part, cost cutting.

So, it was with some shock that we read this article. We would definitely agree with the authors that retrieval of a dislocated humeral head can be difficult and timely. Although undoubtedly the use of a bone anchor placed into the dislocated head would aid in a quick retrieval of the head, we are not sure