Despite an overall death rate of 34–40% for all cases of fulminant *C. difficile* colitis, we considered this cohort to be at the severe end of the '*C. difficile* colitis' spectrum and thus to have a much higher risk of mortality. While we are obviously not advocating *C. difficile* colectomy for everyone with fulminant disease, in our experience colectomy for pseudomembranous colitis can save lives. We accept that it has a high mortality and appreciate that this is not a randomised, controlled trial and, as such, has limitations. However, we advocate early surgical review for all cases of fulminant colitis and recommend that surgery is carefully considered in those patients judged to be deteriorating despite appropriate attempts at medical management.

Wire localisation in breast surgery

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COMMENT ON

Ray K, Chouhan A, Johri A. A simple aid to wire localisation in breast surgery: covering the hook-wire with a needle. *Ann R Coll Surg Engl* 2010; **92**: 78

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We read with interest the technical tip describing the use of a blunt 18-G needle to cover the localisation wire in breast surgery. This technique is already known and in current practice (also mentioned in eMedicine article 'Breast, Needle Localization' by William Teh and Hemant Singhal). We have used this technique for 9 years in more than 300 patients. Accurate localisation was done with minimal morbidity. There were no missed lesions or partial excision in our series. The advantage, as mentioned, is the ability to assess the direction of the wire within the breast tissue thus aiding the placement of the appropriate incision.

However, the applicability of this technique has its difficulties especially when the wire is kinked inside the breast tissue thus making it difficult to push the needle close to the lesion. The other problem encountered is the shorter length of the needle compared to the length of wire within the breast particularly in larger breasts and where the entry of wire is further away from the lesion. However, in these circumstances, the direction of the needle can guide the surgeon to the lesion. Though this Seldinger-type methodology is certainly novel in practice, the technique itself is not new.

AUTHORS' RESPONSE

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Due to the constraints of the number of words allowed in Technical Tips, we were unable to mention the possible problem which you have rightly highlighted. There are ways of overcoming these problems.

In larger breasts, we have used longer lumbar puncture needles to get nearer the tip of the localising wire. We have rarely encountered the kinking of the needle. In cases of needle kinking, the problem is more often due to dense breast tissue which is usually negotiated by using the lumbar puncture needle. We never force the needle. Another useful trick we use in big breasts is to measure the length of wire inside the breast by subtracting the length of it outside the breast from the total length. This helps determine how far the needle needs to be negotiated gently over the wire. If we can not achieve this after a couple of attempts, we abandon the procedure. However, in the majority of patients, we have successfully negotiated the needle nearer to the tip of the localisation wire. Even if one can reach half the length of the wire, it still helps to minimise unnecessary excision of at least superficial tissue thus minimising possible cosmetic deformity.

Acute appendicitis – is there still a place for active observation?

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COMMENT ON

Akbar F, Yousuf M, Morgan RJ, Maw A. Changing management of suspected appendicitis in the laparoscopic era. *Ann R Coll Surg Engl* 2010; **92**: 65–8

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We read the study of Akbar *et al.* with interest and have also