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

that the use of the anchor can be justified and is certainly not a cost-cutting technique. The cost of the described Mitek anchor retails in most NHS hospitals for approximately £180. We live in an era of Payment-by-Results (PbR) and a deteriorating national/international economic recession. I wonder how the authors can really justify throwing away £180 every time they use one of these anchors for a head retrieval? We personally find that a readily available surgical index finger and instruments normally found on most standard orthopaedic trays such as a Homman's retractor can adequately retrieve a dislocated humeral head.

AUTHOR'S RESPONSE

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There is no doubt that using a Mitek anchor to retrieve a humeral head does involve cost. We do not propose that it is used for every fractured humeral head requiring a hemiarthroplasty. We suggest this technique for the very rare occasions where the humeral head is dislocated and initial attempts to retrieve it seem to push it further down into the axilla. Placing instruments blindly around the head when it is sitting dislocated in the axilla is not without risk. It is on these rare occasions that we suggest that surgeons consider using a Mitek to help retrieve the humeral head.

Loin pain haematuria syndrome

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COMMENT ON

Ahmed M, Acher P, Deane AM. Ureteric bupivacaine infusion for loin pain haematuria syndrome (LPHS). *Ann R Coll Surg Engl* 2010; **92**: 139–41.

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Ahmed and colleagues describe a novel method of treating loin pain haematuria syndrome (LPHS). There is no established

treatment pathway for this difficult disorder. The authors have identified aggressive treatment strategies; however, many believe it has a significant somatoform component. Bass *et al.*,¹ in 21 cases of patients referred from regional renal centres found 12 to have recurrent, unexplained symptoms involving other body parts. They now advocate once a diagnosis has been made, that patients are managed in a multidisciplinary regional clinic involving pain consultants and psychiatrists.

LPHS is a diagnosis of exclusion. Therefore, extensive investigation needs to be carried out. Should we be carrying out angiography in these patients to rule out arteriovenous malformations (AVMs)? These may be otherwise missed on IVU/ultrasound giving a presumptuous LPHS diagnosis. Renal AVMs are rare, with a reported prevalence of 0.04%.² However, with LPHS being rarer (estimated prevalence of 0.012%³), should we be standardising our diagnosis of exclusion?

The half-life of bupivacaine is approximately 3 h. It is surprising that 23% of patients treated had complete resolution after one instillation. Furthermore, ensuring enduring absorption and stasis in the renal tract must be difficult at the very least. A placebo-controlled trial would undoubtedly be of great interest.

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We agree entirely that a multidisciplinary approach should be advocated in the management of LPHS. There is certainly a response to intra-ureteric bupivacaine; how much of this is placebo can only be ascertained with a randomised, controlled trial. The point regarding evaluation with angiography is well made and should be considered in this context.