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.

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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.