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

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