Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. Tables and figures should only be included if absolutely essential and no more than five references should be given. The editor reserves the right to shorten letters and subedit contributions to ensure clarity.

Changes required to improve CEA outcomes

Z GAMIE, F WOOD, RS VOHRA, MJ GOUGH

Leeds Vascular Institute, General Infirmary at Leeds, Leeds, UK

doi 10.1308/003588410X12628812459175

CORRESPONDENCE TO

Zakareya Gamie, E: ugm1zg@doctors.org.uk

COMMENT ON

Brown C, Naylor R. Improving the provision of carotid endarterectomy in line with UK Government targets requires more than just motivated surgeons.

Ann R Coll Surg Engl 2009; **91**: 326–9

doi 10.1308/003588409X391712

We read with interest this article regarding improving the provision of carotid endarterectomy (CEA). As noted, achieving a 2-week target requires a change in practice as well as ‘motivated’ surgeons. Historically, CEA was performed more frequently by some surgeons in our unit (7 in total) than others, reflecting referral practices and ‘special’ interests. In order to meet the 2-week target, we developed a policy that all symptomatic patients requiring CEA would be accommodated on the next available consultant operating list. Over the last 6 months, we have achieved 97% compliance with the 2-week target.

With increasing centralisation, many centres now have ‘vascular’ lists most days. We would, therefore, recommend our unit’s policy to others particularly since a recent national audit suggests little improvement in CEA provision since the 2-week time limit was published.¹ In addition, the greatest risk of stroke is within the first few days following the index

neurological event² and awareness amongst the public and GPs regarding the significance of transient ischaemic attacks is poor;³ greater steps are required to identify ‘brain attacks’ early through public awareness campaigns and physician education. We believe that this and the suggested changes in service provision are required to improve overall outcomes.

References

1. Halliday AW, Lees T, Kamugasha D, Grant R, Hoffman A, Rothwell PM *et al.*, Carotid Endarterectomy Steering Group; Clinical Effectiveness and Evaluation Unit, Royal College of Physicians; Vascular Society of Great Britain and Ireland *et al.* Waiting times for carotid endarterectomy in UK: observational study. *BMJ* 2009; **338**: b1847.
2. Rothwell PM, Warlow CP. Timing of TIAs preceding stroke: time window for prevention is very short. *Neurology* 2005; **64**: 817–20.
3. Jagadeham VP, Aparajita R, Gough MJ. Can the UK guidelines for stroke be effective? Attitudes to the symptoms of a transient ischaemic attack among the general public and doctors. *Clin Med* 2008; **8**: 366–70.

Surgical management of Boerhaave’s syndrome in a tertiary oesophagogastric centre

KHURRAM SIDDIQUE, GANDRA HARINATH

Department of General Surgery, William Harvey Hospital, Ashford, UK

doi 10.1308/003588410X12628812459210

CORRESPONDENCE TO

Khurram Siddique, E: sk_sid@hotmail.com

COMMENT ON:

Sutcliffe RP, Forshaw MJ, Datta G, Rohatgi A, Strauss DC, Mason RC, Botha AJ. Surgical management of Boerhaave’s syndrome in a tertiary oesophagogastric centre. *Ann R Coll Surg Engl* 2009; **91**: 374–80.

doi 10.1308/003588409X428298

Sutcliffe *et al.* have produced a well-structured study which describes the surgical management of Boerhaave’s syndrome which is quite a challenging job. Various studies have been performed to propose the best management for the patients who present late. The review by Wang *et al.*¹ describes the surgical management to achieve the best outcome and may lead to reduced mortality. The authors have