techniques. Nevertheless, any needle that breaches the capsule, including during FNA,¹ risks seeding the disease. Identifying such morbidity depends on careful follow-up, which is necessarily poor for the majority of parotid lumps. In addition, it is not clear that USCB is any less operator dependent than FNA.

The choice of preoperative investigations balances the potential diagnostic benefit against the costs and risks of the procedure. Accordingly, there may be a role for USCB in salivary gland tumours but the value of less intrusive FNA cannot be dismissed, especially when cytology expertise is available.

Reference

1. Supriya M, Denholm S, Palmer T. Seeding of tumor cells after fine needle aspiration cytology in benign parotid tumor: a case report and literature review. *Laryngoscope* 2008; **118**: 263–265.

Fingerless gloves for hand trauma cases

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COMMENT ON

Tang SW, Bebbington A. Fingerless gloves for hand trauma cases. *Ann R Coll Surg Engl* 2011; **93**: 175
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Tang and Bebbington have described a simple yet effective method of minimising contamination from adjacent surfaces during hand surgery with the use of a sterile surgical glove to isolate the surgical site. They also proposed the use of a rolled-down finger portion of the glove to be used as a finger tourniquet. The fact that this rolled-down finger tourniquet is not detached from the surgical glove may reduce the risk of leaving the tourniquet in situ after surgery. Iatrogenic digital ischaemic injuries may therefore be avoided.

However, the use of a surgical glove as a digital tourniquet must be employed with great caution. The National Patient Safety Agency (NPSA) reported incidences of digital necrosis requiring subsequent amputation as a result of rubber or surgical glove finger tourniquets being left in situ.¹ In reducing the risks of digital tourniquets being left after finger or toe surgery, the NPSA recommended that digital tourniquets should be brightly coloured and have a CE mark. The use of surgical gloves was also discouraged.

The finger tourniquet described by Tang and Bebbington was highly visible as the rolled-down portion remained attached to the surgical glove. Nevertheless, the use of non-bright coloured surgical glove/rubber as a tourniquet will need to be exercised with caution.

Reference

1. National Patient Safety Agency. *Rapid Response Report NPSA/2009/RRR007: Reducing risks of tourniquets left on after finger and toe surgery*. London: NPSA; 2009.

Authors' response

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While the use of a single finger cut from a glove should be discouraged as mentioned, it is highly unlikely that a surgeon would leave on a whole rubber glove and fail to remove it. Nevertheless, a simple way to avoid this is to use coloured gloves. (Either bright blue latex free or bright green gloves are widely available.) These would be an even bigger visual warning than commercially available finger tourniquets that a tourniquet had been inadvertently left on!

Consent

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COMMENT ON

Bogod D. Consent. *Ann R Coll Surg Engl* 2011; **93**: 265–267
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I read Dr Bogod's article with interest. It raises several important points:

1. The Mental Capacity Act 2005 (MCA 2005) provides for advance decisions to be formulated.
2. The MCA 2005 provides for the appointment of independent mental capacity advocates (IMCAs) but it needs to be clearly understood that the role of these individuals is only to provide background information to the decision maker so that the best interests of the patient can be determined. The IMCA has no role in defining the best interests, is not a decision maker and therefore, most importantly, does not 'act on behalf of incapable patients'. Rather, the IMCA gathers information about the patient that will influence the doctor's eventual decision about what may or may not be in the patient's best interest.

The IMCA would not usually be instructed in the case of Dr Bogod's patient as she is accompanied by her daughter. The IMCAs are generally involved only in the case of 'unbefriended' patients who lack capacity, where there are no other persons who can inform the doctors of matters that may influence the determination of the patient's best interests.

3. Before the advent of the MCA 2005, the common law defence of necessity allowed a surgeon to save the life of (or prevent irremediable harm to) an incompetent patient, usually in a clinical emergency. It needs to be understood that this doctrine would be entirely inapplicable to the case of the elderly patient that Dr Bogod is considering. The 'legal vacuum' that he describes would quite clearly have been filled, prior to the MCA 2005, by a carefully considered clinical decision on the basis of her best interest. If this had proved contentious, it would have been dealt with under the inherent jurisdiction of the High Court.

This procedure has simply been codified into statute by the MCA 2005. Translated into the language of this new law, temporarily incapacitated patients can be operated on solely on the basis of their best interests only to save life or prevent irremediable harm. So if you wish to repair a ruptured aortic aneurysm in an incompetent patient, the 'defence of necessity' is all you require. However, if you wish to replace a hip as an elective procedure, the defence has no role whatsoever since the intervention is not immediately necessary and there should be ample opportunity first to determine the patient's best interests and then act accordingly.

4. The reason why surgeons are so frequently reminded not to regard consent as valid 'no matter how much time has passed' is mainly because unbeknownst to the surgeon, the patient's circumstances (as opposed to the risks and benefits of the procedure) may have changed. The patient may have: a new job, or lost their old one; new family; new mortgage; new partner; lost a child; been widowed; made bankrupt... and all of these may have altered the patient's attitude to whether the surgery is still appropriate from their perspective.
5. In determining what information to provide, you should be guided, as Dr Bogod asserts, by what the reasonable patient would want to know – the reasonable patient being an honourable descendant of the man on the Clapham omnibus. The difficulty with being guided by what a 'particular patient needs to know' (as the Summary suggests) is that you have absolutely no idea what that might be. Naturally, we have a duty to answer any questions during the disclosure process, thus allowing us to get as close as possible to the particular patient's requirements, but how can we possibly know what the person in front of us regards as the cornerstone of his or her decision? It is for this reason that in most jurisdictions, courts have established something approaching an objective standard (in English law: the reasonable patient) for whose benefit doctors formulate the disclosure of risks, benefits, alternatives, etc.

Simplified minimally invasive parathyroidectomy

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COMMENT ON

Wong W, Foo FJ, Lau MI, Sarin A, Kiruparan P. Simplified minimally invasive parathyroidectomy: a series of 100 cases and a review of the literature. *Ann R Coll Surg Engl* 2011; **93**: 290–293
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We agree with Wong *et al* that minimally invasive parathyroidectomy (MIP) is a safe and effective option in selected patients (approximately 50% of those with primary hyperparathyroidism) but would like to comment on some aspects of methodology and conclusions as reported in their case series.

The authors quote a reference from 2003¹ to support their assertion that only a small minority of consultant members of the British Association of Endocrine and Thyroid Surgeons (BAETS) were using the lateral incision approach. The third national audit of the BAETS database in 2009 showed that a targeted approach was used in 35% of patients who underwent first time surgery for primary hyperparathyroidism.²

The series by Wong *et al* reports only on patients in whom MIP was attempted. We assume that there would be other patients with primary hyperparathyroidism who underwent planned bilateral exploration. From an epidemiological perspective (and for readers to obtain a greater insight and perspective into the authors' practice), it is important that the article includes details of all patients who underwent surgery and the results of imaging in those patients who underwent bilateral exploration. In addition, restricting reporting of accuracy of technetium sestamibi (MIBI) scans and ultrasonography to only those who underwent MIP would grossly exaggerate the tests' reported success.

In the Methods section, Wong *et al* state that ultrasonography and/or MIBI scans were used for localisation. A systematic literature review and evidence-based guideline³ confirms our view that unilateral/targeted parathyroidectomy should be used only if MIBI and ultrasonography results are concordant. If parathyroid localisation studies are non-concordant, or only a single scan is positive, the appropriate approach should be bilateral neck exploration or targeted parathyroidectomy with intraoperative parathyroid hormone (IOPTH) assay.

The use of 7.5mg/kg of body weight of intravenous methylene blue is an unnecessarily high dose that has the potential to cause serious neurotoxicity.⁴ The most appropriate 'maximum permitted dose' for intravenous methylene blue has been debated in the literature before.⁵ The general consensus and recommendation by the UK National