Letters and comments

The diagnostic value of fine needle aspiration in parotid lumps

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COMMENT ON

Mallon DH, Kostalas M, MacPherson FJ *et al.*
The diagnostic value of fine needle aspiration in parotid lumps.
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We read with interest the article by Mallon *et al* and would like to make further comment. Their paper documents what is becoming increasingly clear about fine needle aspiration (FNA) in the salivary glands. In experienced hands, it is capable of a high degree of accuracy, and is quick and safe to perform. FNA performance is optimised by the use of ultrasonography guidance, presence of cytologist/cytology technician to allow repeat aspiration and use of ancillary cytology techniques. Outside specialised units, however, the performance of FNA varies widely, as demonstrated in the recent meta-analysis by Schmidt *et al.*¹

Even in optimised circumstances, FNA remains associated with both a high rate of non-diagnostic sampling and also false negative results.¹ These perceived failings have led to investigation into alternative biopsy techniques, which may more reliably provide an accurate preoperative diagnosis, allowing informed patient consent and appropriate operative selection.

Ultrasonography guided core biopsy (USCB) has been described recently in the parotid glands, and has been shown to be both highly accurate and well tolerated.² USCB obtains a core of tissue, using a small bore needle (18G or 20G) deployed via an automated biopsy device, which can be sent for immunohistochemical analysis. This enables typing and grading of tumours. Furthermore, it allows improved diagnosis of nodal hyperplasia and the differentiation of reactive node from low grade lymphoma. USCB does not appear to be associated with either the high non-diagnostic and false negative rates or the variability in performance associated with FNA.³ We would recommend that USCB should be considered the biopsy technique of choice for parotid lump diagnosis, particularly in units where FNA is undertaken in non-optimised circumstances.

References

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Minimally invasive endoscopic therapy for the management of Boerhaave's syndrome

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COMMENT ON

Darrien JH, Kasem H
Minimally invasive endoscopic therapy for the management of Boerhaave's syndrome. *Ann R Coll Surg Engl* 2013; **95**: 552–556
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In this paper, the authors describe minimally invasive endoscopic therapy in a highly selected group of five patients with Boerhaave's syndrome. There are two issues we wish to raise.

First, the authors state that the primary goal of minimally invasive endoscopic therapy is to seal the oesophageal perforation. The results demonstrate that stenting is actually very poor at achieving this goal. Four patients required stents to be replaced owing to ongoing oesophageal leaks. In three of these cases, an oesophagocutaneous fistula was still identified at the time of stent removal. Given these results, the favourable outcomes reported in this paper cannot be attributed to the use of stenting.

Second, the management of the late oesophagocutaneous fistulas was performed using a combined percutaneous-endoscopic rendezvous technique. It is surprising that the authors do not reference that this technique was in fact first reported in 2001 in relation to T-tube insertion.¹

Care must be taken when interpreting the results of endoscopic therapy in such a highly selected patient group. The mainstay of treatment remains surgery or active aggressive but non-operative management in appropriate cases.² The contribution played by stenting in the process of patient recovery remains at best controversial and potentially dangerous.³

References

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AUTHORS' RESPONSE

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Thank you for your comments on this article and the issues that you raise. At the time of managing these patients, we were limited to using the stents that we had available to us in our unit (Ultraflex™; Boston Scientific, Natick, MA, US). When we realised they were not providing an adequate seal, we looked for alternatives and changed to the Polyflex® stent (Boston Scientific). These provided a greater radial force than that of the Ultraflex™ stents, and they were more effective in both excluding the defect from the alimentary tract and preventing the development of further associated mediastinal and pleural collections. Once we were aware that the Polyflex® stent was superior to the Ultraflex™ stent, it was subsequently used as a primary treatment modality without complication.

We are sorry for not citing your unit's paper describing a similar rendezvous type technique to that of our own. I am sure that we would have benefitted from your expertise. We would, however, like to draw your attention to the extensive bariatric literature now available supporting the use of stents in the management of oesophagogastric leaks and perforations.^{1–3} These demonstrate both the safety and efficacy of plastic covered self-expandable metallic stents in managing challenging clinical circumstances.

While we agree that the mainstay of treatment for this condition should be surgical, we are more pragmatic in our approach and recognise that in selected patients who perhaps present late with established multiorgan dysfunction or have significant co-morbidity, a dogmatic approach may be somewhat risky. As such, we put forward our technique for consideration in selected circumstances where surgery may be ill advised.

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Twist-over: stainless steel suture technique for skin graft applications

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COMMENT ON

Shokrollahi K, Sofos S.

Twist-over: stainless steel suture technique for skin graft applications.

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Shokrollahi and Sofos' article is excellent but fails to reference the 'herniotomy approach' published by Choudhary and Lam in 1999,¹ a technique to which theirs bears some core similarities. Choudhary and Lam describe using a silk suture to secure the graft at its periphery, leaving the suture ends long. These suture ends are then drawn together and twisted until they apply sufficient force on the underlying bolster (as repeated in Shokrollahi and Sofos' technique). A single stitch tied around the twisted bundle of threads secures it. Some years ago, we modified this technique such that the final stitch weaves over and under each of the tie-over strands just before they become entwined to stop any slippage.

Although our final suture may add an additional few seconds of operative time compared with the stainless steel 'twist-over' technique, we feel that this is more than compensated for by the use of a significantly cheaper stitch material that can be removed quickly and easily with the use of any blade or stitch cutter.

Reference

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Streptococcal toxic shock syndrome following total thyroidectomy

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COMMENT ON

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Streptococcal toxic shock syndrome following total thyroidectomy.

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We were interested to read this review. In fact, we described this rare but potentially fatal complication following a