

word of caution is necessary before advocating transverse colostomy for faecal diversion in Western patients. This population has a high body mass index when compared to Asians' and a transverse colostomy may be technically difficult to fashion due to a fatty mesentery and a short residual colon following anterior resection. It is also well known that defunctioning stomas can be associated with major complications². There remains the option of a randomized study comparing stomal diversion *versus* no diversion plus Foley catheter drainage.

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- 1 Leenen LPH, Kuypers JHC. Some factors influencing the outcome of stoma surgery. *Dis Colon Rectum* 1989; **32**: 500–4.
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Authors' reply

Sir

We started to perform total mesorectal excision (TME) in 1993 and three colorectal specialists performed all the operations. Over 200 TME procedures had been performed before the initiation of this trial. Closure of the stoma was also performed in the presence of a specialist, though not necessarily a chief surgeon. Loop ileostomy was our preferred option for proximal diversion before this trial^{1,2}; however, small bowel obstruction (SBO) was not uncommon. Our most recent analysis showed that the incidence of SBO following low anterior resection was 13 per cent in patients who had an ileostomy at any stage of their treatment (unpublished data). Gooszen *et al.*³ also reported small bowel ileus as one of the complications after ileostomy in their randomized trial. Moreover, we noted two patients with late SBO of the 40 who had undergone ileostomy closure¹. Therefore, SBO was chosen as the main outcome measure in our trial. We finally recommended loop colostomy, mainly because of the lower incidence of SBO; indeed the rates of other stoma-related complications were similar in the two groups. Finally, colostomy closure has been shown to be an easier procedure⁴.

We agree with Edwards *et al.* that late closure of a stoma may increase the chance of adhesive SBO. However, all the documented episodes of SBO in the study occurred within 6 weeks of initial surgery. The patient mentioned by Edwards *et al.* underwent reoperation 7 days after initial

surgery and the ileostomy was not closed at the same procedure.

The diagnosis of SBO was made using standard clinical features including vomiting, abdominal distension and colicky abdominal pain, as well as radiological features. The objective of this study was to define the early results after stoma closure; the long-term results were not mentioned.

The comment from Arumugam *et al.* about the difference in body mass index between Western and Asian patients is valid. This could account for the difference in our results compared with others^{3,4}. Retraction of a stoma is uncommon in our practice. The current low incidence of stoma-related complications has also been demonstrated in a similar study⁴.

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- 1 Poon RT, Law WL, Chu KW, Wong J. Emergency resection and primary anastomosis for left-sided obstructing colorectal carcinoma in the elderly. *Br J Surg* 1998; **85**: 1539–42.
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- 4 Edwards DP, Leppington-Clarke A, Sexton R, Heald RJ, Moran BJ. Stoma-related complications are more frequent after transverse colostomy than loop ileostomy: a prospective randomized clinical trial. *Br J Surg* 2001; **88**: 360–3.

Randomized clinical trial of Ligasure™ *versus* open haemorrhoidectomy (*Br J Surg* 2002; **89**:154–7)

Sir

Recently several patients have been referred to our unit after Ligasure™ haemorrhoidectomy who have presented up to 1 year following the procedure with soiling, low resting anal pressures and internal anal sphincter defects, suggesting that this operation is not without hazard. Assessment of these patients preoperatively for anal tone and simple questioning concerning function may not be adequate. All new procedures have the potential for anal sphincter damage and their evaluation demands rigorous prospective clinical, manometric and morphological assessment of both the internal and external anal sphincter musculature¹.

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1 Zbar AP, Beer-Gabel M, Chiappa AC, Aslam M. Fecal incontinence after minor anorectal surgery. *Dis Colon Rectum* 2001; **44**: 1610–23.

Authors' reply

Sir

We agree with Arumugam¹ that injection sclerotherapy may lead to adherence of the sphincter muscle to the haemorrhoid that could be demonstrated by histological assessment. However the LigasureTM device does not produce a specimen adequate for histological examination. Importantly, we had no evidence of any functional sphincter deficit at short-term follow-up, and will shortly publish long-term follow-up data that demonstrate no late problems.

Saunders and Abood² question the study design. The anaesthetic technique was standard, as were all other aspects of patient care, as one would expect in a randomized clinical trial. Since pain score and analgesic consumption analysis was commenced the day after surgery, and the anaesthetic drugs were short acting, the analgesia on the day of surgery was not relevant. Also, pain score data are more reliable when documented contemporaneously. Therefore standardizing the time when the form would be at hand (i.e. at home) allowed for a more accurate study. We were a little bemused by the statement that 'the inclusion of men and women may have skewed the results' since the randomization provided almost perfect balance between the sexes.

Finally, we are unable to comment on the experience described by Lascelles *et al.* in the light of our apparently trouble-free long-term follow-up. We look forward to reading their paper detailing the complications they have encountered.

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1 Arumugam PJ. Randomized clinical trial of LigasureTM versus open haemorrhoidectomy *Br J Surg* 2002; **89**: 1068 (Letter).

2 Saunders SME, Abood A. Randomized clinical trial of

LigasureTM versus open haemorrhoidectomy *Br J Surg* 2002; **89**: 1068 (Letter).

Permanent sacral nerve stimulation for treatment of idiopathic constipation (*Br J Surg* 2002; **89**: 882–8)

Sir

The authors conclude that sacral nerve stimulation is an effective treatment for faecal incontinence. Though an interesting and potentially promising technique, one must view these results with a degree of caution. The study group was small and highly selective; all the patients had an intact external anal sphincter and 13 of the 14 patients possessed completely normal pudendal nerve function. Audit of referrals with urge faecal incontinence to our institution revealed that nearly 90 per cent (223 of 252 patients over 7.5 years) had evidence of an external anal sphincter defect and/or prolonged pudendal terminal motor latency. Based on the authors' selection criteria, these patients, who represented the largest clinical group, would have been excluded. In addition, no details were given concerning the number of patients who initially underwent the trial of stimulation but who were deemed unsuitable for permanent stimulation. The authors also appear to dismiss the currently accepted surgical options and suggest that sacral nerve stimulation is the solution for all forms of faecal incontinence. We hold an alternative view that the management of faecal incontinence is complex and a range of current treatments should be adopted, with appropriate patient selection based on careful investigation. Although sacral nerve stimulation represents a novel treatment for faecal incontinence, its benefit in the management of patients with external anal sphincter defect and/or dysfunction secondary to pudendal neuropathy has yet to be established. The conclusions drawn from the study cannot be justified based solely on the treated group.

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Transoesophageal echocardiography shows high risk of gas embolism during laparoscopic hepatic resection under carbon dioxide pneumoperitoneum (*Br J Surg* 2002; **89**: 870–6)

Sir

The authors do not provide data to justify their first conclusion that 'the ultrasonically activated scalpel (UAS)