

Laparoscopy, a tool in diagnosis of lower abdominal pain

Sir,

This has reference to the article by Arya et al.¹

Of late, it has become a routine or a custom or a style to conclude all articles on laparoscopy as "Laparoscopy is safe, quick, cost effective etc. without giving adequate data to substantiate it in the main article. Today, in the era of evidence based medicine (EBM), we cannot make any statement, especially in prestigious journals like IJS, unless supported by adequate data to substantiate. The above conclusion though correct as supported by a number of authors, cannot be quoted in a particular article unless data presented supports it. What is the point in simply making the statement discovered by others? This we all know by reading various text books and journals. Just recently I had written a letter to the editor on this.²

The authors have concluded that laparoscopy is safe, quick and cost effective. There is no cost analysis in the main article. Neither it has been compared with open surgery or any other data to say it is safe and quick.

Also, I notice a number of errors in the article.

1. Statistics.

Table 3, (procedures done) shows that out of 37 procedures 13 are appendicectomy. In this one case turned out to be normal on HPE. So, there are 12 appendicitis cases as proved by HPE. However, Table 4 shows, (Diagnosis after HPE), Appendicitis (Chronic/resolving) 13. If we think "normal" appendix case is also included in this, see No organic cause. This has 5 cases including one normal appendix. How is this possible?

In the discussion part authors write in 3rd para ".....finally only 4 patients required an open procedure or laparotomy performed." However, table 3 shows 5 open procedures- appendicectomy- 3, jejunal resection for diverticula- 1, adhesiolysis- 1.

These are elementary mistakes. These mistakes question the authenticity of the article.

2. Under discussion, in para 2, authors write "laparoscopy is very sensitive for the diagnosis of appendicitis whether acute or chronic." What are the

criteria for diagnosis of chronic appendicitis on laparoscopy (for that matter in open surgery -gross morphology)?

Can authors give references for the "sensitive" criteria and sensitivity of laparoscopy in the diagnosis?

They continue to mention that " It not only detects appendicitis but also avoids negative appendicectomy".

I've done dissertation on appendicitis in my PG days and read extensively on the topic in various journals. One such article I would like to quote here. This is an excellent article all PG students should read to know how an article should be written and how to analyse the data. In this the authors, Hoffman J & Rosmussen OO, have extensively reviewed the articles on aids in the diagnosis of appendicitis. (Aids in the diagnosis of acute appendicitis: BJS 1989;76:8).³ Various modalities of diagnosis are reviewed. The modalities are WBC counts, Urine examination, Plain X ray abdomen, Barium enema, Ultrasound examination, Laparoscopy, Computers, Scoring systems and Miscellaneous (CT scan, Radioisotope scan, diagnostic peritoneal lavage, Barium follow).

On laparoscopy, authors note that sensitivity of 80 to 100% and specificity of 73 to 95% are reported. That means 0-20% cases of appendicitis are still missed in laparoscopy and 5-27% of the appendix removed are "Normal" (Negative appendicectomy). Further, in 7-85% (Average 15%) cases appendix "Couldnot be visualised". So, laparoscopy has succeeded in reducing negative appendicectomy only in 25-50% cases. Infact, none of the investigations mentioned above including laparoscopy could avoid negative appendicectomy. They can only reduce and not avoid negative appendicectomy. The authors of this study are also cautious to mention the disadvantages of diagnostic laparoscopy in appendicitis. It is invasive, requires anesthesia, incidence of complications, requirement of special instruments and expertise. The procedure itself is an operation. So, it is an operation done to avoid another operation (negative appendicectomy). Lastly, an appendix thought normal macroscopically may be inflamed microscopically and vice versa is also true.

I hope to see only articles with conclusions based on evidence in IJS.

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Laparoscopy, a tool in diagnosis of lower abdominal pain: Author's reply

Sir,
The authors are grateful for the critical review of our article in detail and the interest shown by the reader. Such constructive feedback and the discussion create a healthy environment for the future research and publication in IJS.

Sir, it is not because of the recent trend or fashion that we have mentioned about the merits of laparoscopy. We have commented the facts observed by us in our original work and similar results have also been quoted by other researchers, which we have already mentioned. After all the superiority and advantages of the procedure can be authenticated only by us and those who have been working on the problem.

The matter of cost analysis was discussed, when the article was being reviewed by the editorial committee, which the latter preferred to omit. Comparison with open surgery was not part of this study.

The errors in calculation and tabulation are due to oversight, in spite of repeated editing and corrections.

The number of appendicitis cases in table 4 may be read as 12. In the same table the number of patients with no organic cause should be read as 6. In the discussion, in para 3, line 12 the number of patients undergoing open procedures should be read as 5.

No alteration has been made to the content of the study. Such errors cannot put question mark on the authenticity of the useful work done by the authors.

The authors are aware of the article about the macroscopic findings of appendicitis, mentioned in letter.¹ It is indeed a good article but so much details were not warranted in our article.

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Surgical training for overseas doctors in the UK- Facts, realities and solutions! Comments

Sir,
Dr. Raghu's special article¹ on surgical training for overseas doctors in the UK is highly informative and gives essentially right directions to the aspiring young doctors who wish to acquire excellence in the subject of their choice in the UK. It is important for the candidates to realize that they should be well equipped

with degrees, training and publications which could be obtained in India and a secure training post in the UK before leaving their country in order to avoid future disappointments and embarrassment.

Dr. Raghu's article clearly sweeps away the fantasy cloud that seems to envelope many young medical

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