

The Editors welcome topical correspondence from readers relating to articles published in the Journal. Responses can be sent electronically via the BJS website (www.bjs.co.uk) or by post. All letters will be reviewed and, if approved, appear on the website. A selection of these will be edited and published in the Journal. Letters must be no more than 250 words in length. Letters submitted by post should be typed on A4-sized paper in double spacing and should be accompanied by a disk.

Differences in clinical performance (*Br J Surg* 2002; 89: 948–9)

Sir

One factor that may determine different outcomes between surgeons, which never seems to be considered specifically, is case selection, or practice style. Physicians, and occasionally general practitioners, often know to which surgeon to refer the marginal case because they know that surgeon will 'always operate on anything'. This factor may not necessarily be identified by case mix or risk assessment and I suspect it may be as potent a cause of poor performance as suboptimal surgical technique.

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Percutaneous radiofrequency thermoablation as an alternative to surgery for treatment of liver tumour recurrence after hepatectomy (*Br J Surg* 2002; 89: 752–6)

Sir

Radiofrequency ablation (RFA) of liver tumours may be a useful adjuvant therapy for relapsed disease within the liver; however, it has not been shown to be curative in long-term studies. Repeat hepatectomy can provide long-term survival rates similar to those of first hepatectomies, with no mortality and comparable morbidity¹. A 5-year survival rate of 32 per cent is described for repeat hepatectomy for colorectal liver metastases².

There are several problems with RFA not encountered with surgery. These are generally related to dependence on the limitations of current extracorporeal imaging to diagnose and localize disease accurately. In the present series of RFA, the authors have excluded patients with extrahepatic recurrence, but how was the extrahepatic disease confirmed? Was laparoscopy carried out in all cases, as peritoneal disease is difficult to diagnose using radiological investigations? In their mixture of recurrent liver tumours a large subset were hepatocellular tumours; how were these confirmed as carcinomas as opposed to cirrhotic regeneration nodules? Preoperative biopsy of lesions is to

be avoided as this disseminates disease, and RFA can do the same³. The overall accuracy of imaging by any modality is only about 45 per cent when patients come to operation and this is inadequate for planning potentially curative percutaneous treatments⁴.

The authors compare survival data following RFA with a historical series of patients who had repeat hepatectomy but, as they state, the 28 patients with recurrent tumours not suitable for RFA underwent resection. Thus, it is obvious that the patients who underwent RFA were a selected subgroup with low-volume disease and thus their survival cannot be compared with that of the surgery group. Failure of local treatment may manifest itself by dissemination rather than local progression, rendering patients incurable by salvage surgery. The 5-year survival data on recurrent liver tumours treated by RFA are not available and in the long-term RFA may not be as effective as repeat hepatectomy.

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- 1 Adam R, Bismuth H, Castaing D, Waechter F, Navarro F, Abascal A *et al*. Repeat hepatectomy for colorectal liver metastases. *Ann Surg* 2001; **225**: 51–60.
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Botulinum neurotoxin and other treatments for fissure-in-ano and pelvic floor disorders (*Br J Surg* 2002; 89: 950–61)

Sir

This review is a valuable summary of the state of research of botulinum neurotoxin used in the treatment of disorders of the lower gastrointestinal tract; however, the authors did not mention the first publication that described the application of botulinum neurotoxin for the treatment of chronic anal fissure (CAF)¹. The authors, referring to their work published in 2002, report that higher doses led to an improved success rate. In my experience higher doses (50 units botox) can affect the outcome of treatment for CAF².

The authors also did not refer to this paper when stating that topical nitrates potentiate the effect of botulinum neurotoxin². The authors' opinion that injection of botulinum neurotoxin into the external anal sphincter (EAS) is not yet the first-choice treatment for CAF is not convincing. Jost³ injected botulinum neurotoxin into the EAS in 100 patients and showed its high efficacy for CAF. Others have shown similar, or higher, efficiency using even larger doses⁴. It is widely known that botulinum neurotoxin is a safe and effective method of treating CAF, even if doses higher than those administered by Jost are used.

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- 1 Jost WH, Schimrigk K. Use of botulinum toxin in anal fissure. *Dis Colon Rectum* 1993; **36**: 974.
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- 3 Jost WH. One hundred cases of anal fissure treated with botulinum toxin: early and long-term results. *Dis Colon Rectum* 1997; **40**: 1029–32.
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Authors' reply

Sir

Botulinum toxin injected into the external anal sphincter (EAS) is also effective for treating chronic anal fissure (CAF). However, CAF is associated with spasm of the internal anal sphincter (IAS), and the rationale for injecting botulinum toxin into the EAS is therefore unclear. We found that toxin injected into the IAS did not spread to the EAS, and we believe that it is easier to inject the toxin directly into the IAS¹. The role of EAS weakening in the treatment of CAF remains uncertain (healing rate approximately 80 per cent and up to 80 per cent, depending on whether toxin was injected into the EAS or the IAS respectively). Regarding the therapeutic effect of botulinum toxin injection and local application of nitrate or botulinum toxin alone, 30 consecutive patients with anal fissure were studied. It has been documented that combined botulinum toxin injection and local application of nitrate was more effective than botulinum toxin alone². Furthermore, higher doses are not necessary (of 13 patients with chronic anal fissure who received 50 units botulinum toxin, no healing was reported in six)³, as we were able to produce an adequate effect using lower doses. Higher doses will increase costs, and may contribute to the incidence of undesired effects.

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Retrospective study of acute toxicity following short-course preoperative radiotherapy (*Br J Surg* 2002; **89: 889–95)**

Letter 1

Sir

It is still unclear whether patients with tumour node metastasis (TNM) stage IV rectal cancer benefit from preoperative radiotherapy. There is no evidence to suggest that these patients 'could be spared potential toxicity of short-course preoperative radiotherapy'. In the cited Dutch total mesorectal excision (TME) trial¹ radiotherapy had no effect on local recurrence in patients with stage I and IV disease in a univariate analysis, but in multivariate analysis no significant interaction was found between the TNM subgroup and treatment effect. In fact, patients with distant disease who received radiotherapy had a 10.1 per cent local recurrence rate at 2 years *versus* 23.8 per cent for patients who had no radiotherapy. Lack of statistical significance of this difference may be related more to small sample size than to ineffectiveness of the radiotherapy. The randomized controlled trials to date^{1–3} do not provide definitive conclusions about use of radiotherapy in patients with metastatic disease, mainly because such patients are not enrolled in trials if identified before operation. However, there are at least two subgroups of patients with distant disease who may benefit from radiotherapy: patients with resectable distant disease and those in whom control of metastases can be achieved with local ablative techniques.

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Letter 2

Sir

Toxicity with this multimodality therapy is a major concern, but which modality dominates the toxicity – surgery or radiotherapy? It would be useful to evaluate acute radiation toxicity by applying a validated scoring system, such as the Common Toxicity Criteria¹ or Radiation Therapy Oncology Group scales². Permanent radiotherapy toxicity may be due to persisting acute reactions³. The authors report a 9 per cent mortality rate within 3 months of commencing radiotherapy, but do not include the causes. In our series⁴ we have treated 43 patients with rectal cancer and have encountered no radiation-related mortality. Surgery should be performed within 7 days of radiotherapy to avoid downstaging the tumour and excess cardiovascular mortality. Patients who are downstaged from node positive to node negative tend to have a worse outlook than genuinely node-negative patients. In this study, the median interval between radiotherapy and surgery was nearly 2 weeks. Is it possible that the poor prognosis tumours were hidden by this downstaging effect? We also found a significantly higher incidence of long-term toxicity in patients with tumours of the lower third of the rectum.

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- 1 National Cancer Institute. *The Common Toxicity Criteria Index*. Bethesda, Maryland: National Cancer Institute, 1999.
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- 4 Prabhudesai AG, Cornes PGS, Glees JP, Kumar D. Long-term toxicity following short-course pre-operative radiotherapy and total mesorectal excision surgery for rectal cancer. *Colorectal Dis* 2002; **4**(Suppl 1): 54.

Authors' reply

Sir

We thank Prabhudesai *et al.* for highlighting the difficulty in determining which modality is responsible for toxicity following multimodality treatment. It was our intention to document all postoperative complications, regardless of cause. Of the 15 patients (9 per cent) who died within 3 months of commencing short-course preoperative radiotherapy, the causes of death were septicaemia (five), pneumonia (three), cardiovascular events (two), pulmonary embolus (two), gastrointestinal haemorrhage (one), small bowel obstruction (one) and unknown (one). As this was not a randomized trial comparing short-course preoperative radiotherapy followed by surgery with surgery alone, it would not be possible to relate a particular complication to a specific modality. Equally, the above statement applies to their study of 43 patients¹. While we accept that there were no deaths directly attributable to radiation, it is surprising that only 53 per cent of patients were alive at 1 year. We would be interested to know the cause of death in the 20 patients (47 per cent) who died within 12 months. Although the comments with respect to toxicity scoring systems are valid for late toxicity, in this study, examining acute toxicity, we have reported stochastic events. We would also be most interested to know the evidence for their statement that patients who are downstaged from node positive to node negative tend to have a worse outlook than genuinely node-negative patients.

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