Who should do thyroid surgery?

Sir,

In this issue (p. 756), David Watkin makes an honest and open appraisal of the considerations around 'Who should do thyroid surgery?'. The British Association of Endocrine Surgeons (BAES) endorses his conclusions that thyroid surgery should be concentrated and that thyroid surgeons should participate in a national audit programme and probably be regionally based and linked to a recognized cancer centre.

The study of Asimakopoulos et al (1995) demonstrated that 34% of thyroid operations could have been avoided if a firm preoperative diagnosis had been achieved and only 8% of those who underwent thyroidectomy were investigated by needle cytology. Where is evidence-based surgical practice?

In addition, surgeons will need to achieve a sufficiency of patient numbers so that their results can be audited. If you only do one thyroidectomy a year should we have to wait 50 years to know whether that first recurrent nerve you injured was the only one?

Length of stay and complications are determined by surgeon experience (Sosa et al, 1998), as shown in *Table 1*.

Harness et al (2000) suggest that patients requiring thyroidectomy should be cared for in appropriate centres where there should be increased efficiency, increased quality of care, decreased costs, an individualized approach to surgery, low complication rates and increased likelihood of research and technology development to enhance care.

The BAES takes the responsibilities for quality of care and audit of surgical practice very seriously. If you do too then why not join the BAES? Contact Mr BJ Harrison, Honorary Secretary (Barney.Harrison@northngh-tr.trent.nhs.uk).

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TABLE 1.
Length of stay and complication rates for surgeons with differing amounts of experience

No of thyroid operations per surgeon	Length of stay (days)	Complication rate (%)
1–9	2.8	8.6
10–29	2.1	6.1
30–100	2.2	6.1
100	1.7	5.1

Adjusted for case mix and hospital volume. *This group included a higher proportion of total thyroidectomy and a higher proportion of patients with cancer

Management of the acute abdomen

Sir,

I read with interest the editorial 'The acute abdomen and its management' by Mr Paul Carter (Vol 61(10, 2000, p. 688). It is worth noting that medical diagnoses can mimic the acute abdomen, as highlighted by the following case.

A middle-aged sulphonylurea-controlled diabetic was listed for appendicectomy. At anaesthetic assessment, he looked unwell, dehydrated, tachycardiac, tachypnoeic and pyrexial. He had tenderness and guarding in the right iliac fossa, and a few crepitations at the right base of his chest. His BM was elevated at 20. After discussion with the surgeon, his operation was deferred for resuscitation and further investigation. After volume resuscitation, his metabolic acidosis improved. Ultrasound of the appendix was negative, and chest X-ray showed right lower lobe consolidation. After antibiotics to treat the pneumonia, his condition and diabetic control improved.

The patient with endocrine disease presents yet further diagnostic difficulties: in diabetics, hyperglycaemic states can mimic the acute abdomen (Vetshev et al, 2000), and they are more prone to vascular complications (Sharieff et al, 1997). Other metabolic conditions, such as hypercalcaemia, can mimic surgical abdominal pain (Scott-Coombes and Williams, 1998), and should be included in the differential diagnosis.

Stephen M Edwards
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