Medical causes of GI symptoms

Sir,

The article on investigation of colonic disease (Vol 61(10), 2000, p. 692) was an excellent review of the investigations available to detect structural abnormalities causing lower gastrointestinal symptoms. While it is vital to detect structural pathology, many common medical problems may present with lower gastrointestinal symptoms.

Hypothyroidism, hypercalcaemia and hypokalaemia all cause constipation. Hyperthyroidism and coeliac disease often present with diarrhoea. Coeliac disease needs to be specifically thought about (and anti-Endomysial antibodies checked) as diagnosis can otherwise be delayed.

Unlike the other causes of lower bowel symptoms, coeliac disease will not be detected on routine 'screening' blood tests. It must be remembered that investigating for medical causes of lower bowel disturbance are complementary to radiological and endoscopic investigations and not substitutes.

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Who should do thyroid surgery?

Sir,

I am pleased on behalf of otolaryngology to reply to Mr Watkin's editorial *Who should do thyroid surgery?* (Vol 61(11), 2000, p. 756). I do not think there is anything between otolaryngology and general surgery and agree that anybody who has been trained to can do thyroid surgery, but they should have enough work to maintain their skill and of course work in a multidisciplinary environment, participate in audit and be able to deal with a large range of thyroid disease and potential complications.

I quite agree that there is a general surgical tradition which is strong in thyroid surgery, but at the moment more than a quarter of thyroid surgery in this country is being performed by ear, nose and throat (ENT) surgeons who usually adopt a multidisciplinary approach.

The ENT interest in thyroid surgery is actually long standing, but has increased recently because of a variety of factors. First, the ENT surgeon is in the neck many times a week and management of the thyroid is an intrinsic part of head and neck surgical oncology. An ENT surgeon can offer a multidisciplinary approach to the neck and thyroid, and has experience in fine needle aspiration cytology, can assess the airway, has expertise in resection and repair of the visceral structures surrounding the thyroid and can also offer opinions on the voice and vocal restoration should there be damage to the recurrent laryngeal nerve.

Otolaryngologists are also used to dealing with lumps in the neck, which of course often includes lumps in the thyroid. Training and management of surgical aspects of thyroid disease is intrinsic to the otolaryngology syllabus now and in future all otolaryngology trainees will have to demonstrate knowledge and competence in the management of surgical aspects of thyroid disease.

Obviously, as in most things, the more you do the tendency is the better you do it and it would be better if thyroid surgery is limited to those with expertise. The decision of who undertakes thyroid surgery within the trust should not be based on whether it be general surgery or otolaryngology but which team offers the best multidisciplinary service. As such there is no reason why both otolaryngology and general surgeons should not be part of that team.

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Watkinson JC (1998) Tumours of the thyroid gland. In: Jones AS, Hilgers FJM, Phillipps DE, eds. *Diseases of Head and Neck, Nose and Throat.* Arnold, London: 347–70

Watkinson JC, Gaze MN, Wilson JA (2000) Tumours of the thyroid and parathyroid glands. In: Watkinson JC, Gaze MN, Wilson JA, eds. *Stell & Maran's Head and Neck Thyroid Surgery.* Butterworth Heinemann, London: 459–85

Corrections

In the article on spinal anaesthesia for caesarean section (Vol 61(12), 2000, 855), the incorrect units were given on p. 856. the measurements for diamorphine and fentanyl should have been given in μg rather that mg. We apologise for any confusion this may have caused.

In the article on vaginal hysterectomy (Vol 62(1), 2001, p. 33), *Figures 2, 3* and *5* were unfortunately reproduced in the wrong orientation. *Figures 2* and *3* should have been rotated anti-clockwise by 90°. *Figure 5* is reproduced correctly below.

In the case report on revision total hip arthroplasty (Vol 62(1), 2001, p. 49), *Figure 1* was reproduced incorrectly. The correct figure is reproduced below.

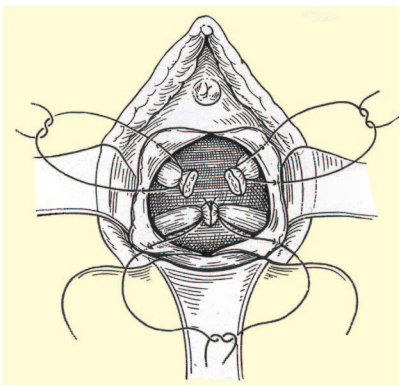

Figure 5. Diagrammatic representation of vaginal vault support. Uterosacral pedicles are tied to each other within the vaginal vault and also exteriorized at the 5 and 7 o'clock positions and tied to each other. The tubo-ovarian pedicles are exteriorized and tied to themselves, so rounding the vault.

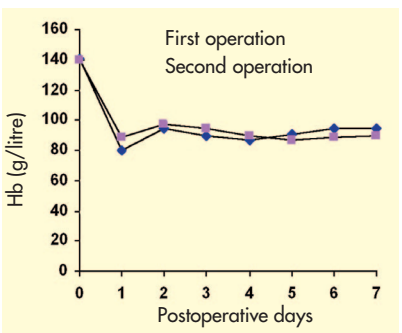

Figure 1. Haemoglobin values from before surgery to day 7 (before discharge).