Reference
1. Lindsey B, Campbell WB. Rationing of treatment for varicose veins and use of new treatment methods: a survey of practice in the United Kingdom. *Eur J Vasc Endovasc Surg* 2006; **32**: 272.

AUTHORS' RESPONSE

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MK NASR, M HORROCKS
Department of Vascular Surgery, Royal United Hospital, Bath, UK

CORRESPONDENCE TO
MK Nasr, Department of Vascular Surgery, Royal United Hospital, Bath BA1 3NG, UK. E: mohamed.nasr@btinternet.com

We owe Professor Campbell an apology for our failure to quote his electronic paper on varicose veins treatment rationing; despite that, we quoted two of his papers as an incentive for us to conduct our study. Regrettably, the keywords used for our search did not retrieve the electronic publication. We tried to search for Professor Campbell's article, after receiving his comments, using Medline and the NHS National Library for Health resources, but we hit a blank search results even by trying the search using both the authors and the full article title. Only when we 'googled' the full title did we find the reference (a drawback of electronic publishing?).

We can still claim that our survey was the first survey to paper publish rather than electronically publish, but we agree with all of Professor Campbell's other comments. However, despite the similarities between the two articles, our article remains unique in highlighting the huge regional variations existing in the UK, which was the main aim of the article.

COMMENT ON

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MM Hoosein, H Towse, G Conn, DL Stoker. Consenting practice for open inguinal hernia repairs – are we failing to warn patients of serious complications? *Ann R Coll Surg Engl* 2008; **90**: 643–6

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Inguinal hernia repair – trends in litigation

N PAWA[1], E YPSILANTIS[2]
[1]Dept General Surgery, Colchester Hospital, Colchester, UK
[2]Dept General Surgery, The Queen Elizabeth Hospital, King's Lynn, UK

CORRESPONDENCE TO
Nikhil Pawa, Dept General Surgery, Colchester General Hospital, Turner Road, Colchester CO4 5JL, UK. E: nikhil@pawa.me.uk

Hoosein and colleagues have correctly identified gaps in the consenting process for inguinal hernia repairs. Analysing data from the NHS Litigation Authority reveals a total of 223 claims following inguinal hernia repair made during the period 2002–2007.[1] At the time of analysis, 159 of these cases were closed, representing 5.4% of the total closed cases relating to general surgery during that time period. Damages were paid in 64 cases ('paid/closed' ratio[2] of 40.3%), summing up to a total of £1,636,510 (range, £600 to £170,000). Interestingly, 13 patients based their claim exclusively on 'failure to be warned on the potential complications of the procedure'. Six patients had fatal outcome and another 11 patients had to undergo orchidectomy as a result of ischaemic orchitis. Further aetiological analysis is presented in Table 1.

Table 1 Aetiological analysis of complaints and litigation costs associated with hernia surgery during period 2002–2007 (NHS Litigation Authority)

Causes	Closed	Paid	Paid/ closed (%)	Mean comp'n/ case (£)
Haemorrhage/haematoma	5	2	40.0	50,396
Visceral injury	21	10	47.6	42,150
Operation failure	19	11	57.9	33,981
Ischaemic orchitis	35	14	40.0	25,633
Infection	17	8	47.1	22,938
Chronic pain	18	2	11.1	13,750
Other (non-specific)	29	10	34.5	13,146
Wrong side operation	2	1	50.0	6,500
Venous thrombo-embolism	3	1	33.3	6,000
Wound complications	10	5	50.0	5,320

Comp'n = Compensation. The 'paid/closed' ratio indicates the likelihood of a claim to lead to compensation.[2]

It is evident that the current consent process can potentially fail to inform patients effectively on the sinister risks associated with hernia surgery, thus leading to postoperative patient dissatisfaction and litigation with significant costs for the NHS. Junior trainees need to be appropriately educated on the above risks. We further support the move towards procedure-specific consent forms for such commonly performed operations.

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