

Table 1. Operating Surgeon

	CV	CG	Registrar	Other	SHO	Total
Nerve Damage:						
Saphenous n	0	5	3	0	0	8
Sural n	0	7	8	0	0	15
Com. Peroneal n	4	7	6	0	1	18
Cutaneous n	2	9	8	1	1	21

CV = Consultant Vascular Surgeon, CG = Consultant General Surgeon (Adapted from *Clinical Risk* 2005;11(6):225–230).

just reviewed 200 consecutive medicolegal claims, during the period 1990 to 2002, following the treatment of varicose veins in the UK.² Sixty two claims (31%) related to nerve damage (Table 1), 18 (9%) of which were due to a CPN injury. Six of these occurred during surgery for recurrent varicose veins.

Although the CPN certainly is at risk in the popliteal fossa and also around the neck of the fibula during avulsions, in the 18 cases that we have reported, 17 followed saphenopopliteal ligation. Only one claim resulted from a ministab avulsion injury. One of the claims that has been settled was due to the short saphenous vein (SSV) being stripped from the ankle and cutting down onto the stripper in the popliteal fossa. Another claim involved both the popliteal vein and CPN being injured during the same procedure!

Eleven of the 18 claims of CPN damage resulted from surgery performed by a Consultant, 4 of these were Consultant Vascular Surgeons. A survey of the management of the SSV by members of the Vascular Surgical Society of Great Britain and Ireland revealed considerable variation amongst the members of the Society, in how they investigate and manage short saphenous varicose veins.³ Only 54% of members of the Society routinely have the saphenopopliteal junction marked by duplex prior to surgery and 14.5% of them routinely stripped the SSV. Lucertini *et al.* reported their experience of CPN injury following SSV surgery to be 2%.⁴

Settlement amounts paid out following a CPN injury, that have been disclosed, range from £14,000 to £112,000.² However, this does not include the legal costs. Where there is a delay in diagnosis and referral to a specialist following a CPN injury the outcome is poor. Special damages for a claimant left with a foot drop can be considerable.

Giannas *et al.* are correct that a poor understanding of anatomy results in damage to the CPN, but the majority of these injuries, that have proceeded to a medicolegal claim, have occur during saphenopopliteal ligation.

J.R.H. Scurr¹ and J.H. Scurr^{2*}

¹Royal Liverpool University Hospital

²The Lister Hospital,

Chelsea Bridge Road,

London SW1W 8RH, UK

E-mail address: jscurr@uk-consultants.co.uk

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The Prevalence, Physical Characteristics and Diagnosis of Nutcracker Syndrome

Dear Editor,

We read with interest an article on “Current Trends in the Diagnosis and Management of Renal Nutcracker Syndrome: A Review” by Ahmed *et al.*¹ They reported that nutcracker syndrome is not very common and few patients have presented in adolescents. Although the prevalence of this syndrome is unknown, Okada *et al.* reported that nutcracker syndrome might be one of the important causes of gross or microscopic haematuria with a relatively high prevalence in children according to their sonographic criteria,² suggesting this syndrome might had been underestimated in the past.

They also described that many sufferers are of above average height and tend to have an asthenic built. Although anthropometric analyses have not been performed in patients with nutcracker syndrome,

*Corresponding author: John H. Scurr, FRCS, The Lister Hospital, Chelsea Bridge Road, London SW1W 8RH, UK.

our previous report suggested that body mass index could influence the peak blood flow velocity in the aortomesenteric portion of the left renal vein.³

In addition, considering the noninvasiveness, high sensitivity, and easy applicability of renal Doppler ultrasound,⁴ patients with mild renal symptoms, especially children or adolescents, might not require further evaluations, such as CT angiography or magnetic resonance angiography, because our previous report³ demonstrated the usefulness of follow-up renal Doppler ultrasound without further diagnostic procedures.

Therefore, diagnostic procedures should be selected according to the characteristics of an individual patient due to variable expressions of this syndrome from asymptomatic microscopic haematuria to severe pelvic congestion syndrome.

J.I. Shin,¹ J.S. Lee^{1*} and M.J. Kim²

¹The Institute of Kidney Disease,
Department of Paediatrics,

²Diagnostic Radiology, Yonsei University College of
Medicine, Seoul, Republic of Korea

E-mail address: jsyonse@yumc.yonsei.ac.kr

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Letter to the Editor re EJVES2863

To the Editor,

This study prospectively compares endoluminal thermal ablation (VNUS) of the long saphenous vein versus “traditional redo groin surgery” (RGS) plus LSV stripping in patients with recurrent reflux after sapheno-femoral ligation without LSV stripping.

In 16 patients, one leg chosen at random was treated with VNUS, the other leg was treated with RGS plus stripping of the LSV.

VNUS caused less pain and bruising and was performed more quickly than RGS. The authors conclude that “VNUS should be considered the treatment of choice for recurrent long saphenous varicose veins”.

As the authors admit in the discussion, the combination of recurrent SFJ reflux and the persistence of a long saphenous vein is “a legacy from the practice of general surgeons in the past who did not routinely remove the LSV”. In my own practice which includes about 2000 LSV strippings and 400 RGS I have encountered this constellation three or four times only.

Any conclusion that can be drawn from this study is limited to this particular constellation which is increasingly irrelevant in daily practice. Nevertheless, the authors’ conclusions may wrongly suggest that VNUS can play an important role in the treatment of recurrent varicos veins.

M. Enzler*

Klinik Hirslanden, CH 8032 Zurich, Switzerland

E-mail address: markus.enzler@hirslanden.ch

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Letter to Editor: Comment on: Current Trends in the Diagnosis and Management of Renal Nutcracker Syndrome: A Review.

*Corresponding author. Dr Jae Seung Lee, MD, 134 Shinchon-Dong, Seodaemun-Ku, 120-752, C.P.O. Box 8044, Department of Paediatrics, Yonsei University College of Medicine, Seoul, Republic of Korea.

*Corresponding author. Dr Markus Enzler, Gefässzentrum Hirslanden, Witellikerstrasse 40, CH-8029 Zurich, Switzerland.