none of us have extensive experience of using deep vein, on two occasions I have attempted anastamosis without the gusset, I have found difficulty in persuading a rather friable 11 mm or 12 mm deep vein to stretch over an 18 mm or 20 mm diameter aorta. On both occasions I found the tension sufficient to cause small tears in the vein and I feel that the basic surgical principle of not suturing under tension by inserting the gusset to be a more comfortable option. Perhaps I have just been unlucky with small veins and big aortas.

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Endoscopic Thoracic Sympathectomy

Sir,
The authors of this study may be surprised to learn that the operation of Endoscopic Thoracic Sympathectomy (ETS) was not invented in Vienna by Kux but was first performed in England by Hughes in 1942. Is this another example of the British tradition of allowing our inventions to be developed elsewhere?
The questions and answers in this survey show just how far we have lagged behind the rest of the world:

- The procedure is now abbreviated to ETS.
- Double-lumen anaesthesia has been abandoned.
- Bilateral procedures are always performed.
- Vascular disorders rarely respond to ETS.
- The Kuntz nerve is not a cause of failure.
- Use of an infraclavicular port is uncommon.
- Isolated axillary hyperhidrosis is best treated by Botox injection.

Support for all these statements comes from the 4th International Symposium on Sympathetic Surgery held in Finland in June 2001. (The proceedings have been published in Annales Chirurgiae Volume 90, No 3). Only two consultants and two trainees from the U.K. attended this meeting. It was decided to form an International Society for Sympathetic Surgery (under the Presidency of Dr Christer Drott) which will be formally launched at the next meeting in Erlangen in 2003. I would encourage all U.K. surgeons performing ETS to contact me so they may go on the mailing-list for the society. Hopefully this would help restore our proper place in the ETS community.

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References


Systemic Effects of Intermittent Claudication

Sir,
The paper by Lewis et al. is of importance given the relationship between exercise in claudicants and its associated inflammatory response. However, there are several important points to raise regarding the methodology of assessment of the systemic effects of claudication. The use of the urine albumin to creatinine ratio (UACR) may not be as useful an indicator of systemic vascular permeability as previously thought. The UACR is affected by both the endothelial integrity of the renal glomerulus as well as renal haemodynamic factors. In particular, any change in renin or catecholamine levels will alter the transglomerular filtration pressure and hence microalbumin excretion. As the relationship between creatinine excretion and albumin excretion is not linear, expressing the rate of albumin excretion as the UACR cannot adjust fully for potential changes in renal haemodynamic factors. Hence, changes to the UACR in this study may simply be a reflection of less catecholamine release commensurate with less pain from claudication following successful angioplasty. Mattei et al. made a detailed analysis of the relationship between microalbuminuria and renal haemodynamics. They