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DOI: 10.1002/bjs.4422

Letter 2: Parastomal hernia (*Br J Surg* 2003; 90: 784–793)

Sir

I write as a representative of one of the most active patient support groups in the UK, and as a colorectal surgeon. I would like to congratulate Carne and colleagues on their most timely review. Not only do they stress the high incidence of the problem but suggest methods of therapy and of equal importance, prevention: a complication rate of up to 48 per cent must be considered unacceptable. Complications such as prolapse and retraction seem common and may cause equally difficult management problems. Surgeons must now concentrate on developing techniques that might prevent them.

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Randomized clinical trial and economic analysis of four-layer compression bandaging for venous ulcers (*Br J Surg* 2003; 90: 794–798)

Sir

The BMI of patients should have been recorded in this study, as obesity is associated with chronic venous insufficiency, a known risk factor for venous ulceration[1]. The infection rates and the incidence of recurrence of the ulcers would have been useful. The cost of educating the community nurses to use four-layer bandaging (4LB) also appears to have been overlooked in the final analysis.

The authors' conclusion that 4LB is the most effective method to treat venous ulcers in the community should be interpreted with caution. Though 4LB was effective compared to the control group's usual system of care (non-standardised), it was not compared with another form of compression (elastic, inelastic, cohesive etc), as only five patients among controls seem to have received compression. In addition, as compression treatment expedites healing of venous ulcers[2,3] it could be argued that any form of compression would have facilitated healing in the study group. Chronic venous ulcers produce copious exudate, necessitating frequent dressing changes and in such instances, single layer compression is more practical and has better patient compliance. As the authors agree, the cost of 4LB dressing materials is high and some ulcers could be managed with single layer compression alone at a reduced cost. Therefore, a pragmatic approach should be adopted to choose the most appropriate and cheapest compression for individual patients.

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DOI: 10.1002/bjs.4424

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2 Marston WA, Carlin RE, Passman MA, Farber MA, Keagy BA. Healing rates and cost efficacy of outpatient compression treatment for leg ulcers associated with venous insufficiency. *J Vasc Surg* 1999; **30**: 491–498.
3 Fletcher A, Cullum N, Sheldon TA. A systematic review of compression treatment for venous leg ulcers. *BMJ* 1997; **315**: 576–580.

Magnetic resonance imaging for primary fistula *in ano* (*Br J Surg* 2003; 90: 877–881)

Sir

This study seems to exaggerate the importance of MRI for primary fistulae. The positive therapeutic impact for three patients was of a relatively minor nature and in all cases the correct diagnosis would almost certainly have been made with repeated examinations supplemented by anal endosonography. The serious discrepancies and major differences in fistula classification resulting from overdiagnosis by MRI in this series, and noted by others[1], should be cause for concern. Injudicious probing in the search for MRI-diagnosed extrasphincteric and suprasphincteric tracks in two patients might have resulted in difficult iatrogenic fistulae when the true tracks were more simple. Fistula persistence and recurrence are frequently attributed to incorrect diagnosis and management[2], and this paper illustrates the prime importance of accurate clinical examination, rather than the value of MRI.

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DOI: 10.1002/bjs.4425

1 Gustafson U-M, Kahvecioglu B, Astrom G, Ahlstrom H, Graf W. Endoanal ultrasound or magnetic resonance imaging for preoperative assessment of anal fistula: a comparative study. *Colorectal Dis* 2001; **3**: 189–197.
2 Seow-Choen F, Phillips RKS. Insights gained from the management of problematical anal fistulae at St. Mark's Hospital, 1984–88. *Br J Surg* 1991; **78**: 539–541.