

**COST EFFECTIVE**

In the main article author have not given any data on the cost-effectiveness or analysis of the cost of surgery. Neither have they compared laparoscopic repair with open surgery (herniotomy) to show that it is superior to herniotomy.

To my knowledge many centers are doing herniotomy as day care procedures. I’ve seen our pediatric herniotomy patients start playing normally within 36 to 48 hours (early return to unrestricted activity referred to above).

Operative time –conventional surgery is also done as fast as, probably faster than, laparoscopic repair.

Reduction in the period of absence for the parents- Most of our patients are from rural area. Mothers are housewives. So this factor is not significant. Even in the case of both parents employed, they plan it on Saturday so that next day will be holiday. From Monday they can go to their duty normally. Hence, herniotomy can be done with one-day leave or even without a leave.

Without referring to any of these things in the main article, it is wrong to conclude “it is cost effective”.

**COSMETICALLY SUPERIOR**

Inguinal skin crease incision used in the herniotomy is one of best incisions as far as cosmesis is concerned. It is hardly visible after a few months. Also, it covered in the underwear. Compared to this three stab incisions, however small, are in the visible area (if the patient’s habit of dress is so). So, is it appropriate call laparoscopic surgery is cosmetically superior?

**SAFE**

In the article itself authors have mentioned 4 recurrences and one hydrocele. In my 11 years of experience I am yet to see a recurrence or hydrocele after herniotomy (Either done by me or any other surgeon). Reason may be inexperience. But herniotomy gives good results in the hands of relatively inexperienced surgeons. This implies risk of another surgery (And anesthesia). To say safe it should not only comparable in mortality but also in morbidity.

**FEASIBILITY IN BILATERAL CASES**

The only conclusion addressed in the main article. Even here, herniotomy is also feasible. Of course, with two incisions.

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**Letter to Editor**

Sir,

It was quite interesting to read the special article on ‘The case report’ by Dr.Pujari. Case report are “like birds tossed over a stormy ocean : only a few gain a foothold in the rigging of passing ships – for the rest , oblivion”.

Though most of the reputed journals with high impact factor do not encourage publication of case reports, there is also an apathy amongst surgeon to report such cases due to lack of recognition of their uniqueness, a misdiagnosis or lack of thought or desire to disseminate the information. Case report should be written to inform rather than to impress, and in doing so using clear and purposeful prose that is accurate and concise.

Case report are an ideal ground for novice / ‘debutant’ authors to produce scholarly work during their postgraduate training. In general, the completion of case report is easier and less time consuming and paradoxically, leads to a temptation to write up anything that is remotely interesting in the hope to see one’s name in print. Therefore, there is always an antagonism between evidence – based medicine and case reporting . New Zealand Medical Journal has ‘ Case note’ instead of ‘Case report’.

Finally, Sorinola et al reviewed 249 journals and concurred that ‘Instruction to authors’ pages provided
limited and varied information for preparing a case report. They recommended a need for consensus and more consistent guidance for the authors of case report.  

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“The case report” Author’s reply

Sir,  
I appreciate the communication from Dr. Bhattacharaya. I hereby offer some comments.

If the case report is submitted to appropriate journal, if the instructions are strictly followed and if the report has a clinical message, such case report is less likely to go into ‘oblivion’. Any such case if rejected by 2 or 3 journals is probably not worth reporting. Author may try luck in ‘Images or Quiz’. As a matter of fact the Editor of IJS in his editorial has welcomed the case reports and innovations.  

In today’s explosive scientific climate, with economic constraints and demand from scholars, the leading journals are pragmatic in focusing attention on evidence based material rather than single case reports. The case reports are written by practicing clinicians while the research or trial papers are usually written by the scholars as it forms a part of their carrier. It is inappropriate to say that surgeons in general fail to recognize the ‘uniqueness’ of the case or always misdiagnose the case. Obstacles in writing like laziness, reluctance, inertia of habit, inexperience, absence of enthusiasm to acquire art and skill in writing etc have been enumerated in my paper “How to Write a Medical Paper”.  

Writing case report proportionately consumes more energy and is rather difficult to write as it has no uniform format and it is less likely that students during in their postgraduate training can produce scholarly work without the help of seniors. Though the postgraduates should be primarily taught to write a good thesis or dissertation, many seniors use their services to collect the references and to prepare a preliminary note for their manuscript. The post graduates in turn do get some experience in searching literature and in preparing the rough draft. The PG student should consider himself lucky if he finds his name in the final list of authors.

Finally it is difficult to provide uniform guidelines for case report. In spite of instructions for uniform requirements for manuscripts submitted to biomedical journals by International Committee of Medical Journal Editors, every journal specifies some guidelines depending on the objective and readership of that journal and hence this attempt to provide wider information on writing “The Case Report”.

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