Dear Editor,

I read with interest the ‘Letter to the Editor’ by Ashutosh Chauhan on the ‘Use of skin stapler in Lichtenstein’s Mesh Repair’ in the February 2005 issue. I had previously read the article on the same subject by Garg et al.

I have also used skin stapler in this procedure. My observations and suggestions are as follows:

• Now-a-days we avoid suturing mesh with periosteum of pubic tubercle because it may give rise to osteitis pubis. Instead, we fix it near the aponeurotic tissue there.
• Around 2.5 cm of the mesh has to be kept protruding beyond pubic tubercle.
• Because the femoral vessels are underlying the inguinal ligament, it is preferable to use prolene sutures in this area to fix the mesh.
• Broad head of the stapler is definitely cumbersome to maneuver but can be managed by retraction of the skin flaps.
• Formerly an end-on skin stapler was available and that was very convenient and ideal to use.
• Once the staples are applied, they remain in position. We had confirmed this in some of our patients by X-rays taken after a few months.

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Letter to Editor

Dear Editor,

I read the article by Singh with interest. He has nicely presented a series of 20 patients who underwent laparoscopic cholecystectomy in second and third Trimester of Pregnancy. I agree there is good evidence in literature of successful laparoscopic cholecystectomy in pregnancy. However I just want to emphasize that gall stone disease treatment in pregnancy is same as in nonpregnant patients. Conservative treatment is the first line of treatment and if surgery is required laparoscopic cholecystectomy can be done safely with precautions as mentioned by Singh et al. While there is increasing trend towards laparoscopic cholecystectomy in acute cholecystitis it should not be the case during pregnancy without conservative treatment. Muench has shown that delay in laparoscopic cholecystectomy in patient with recurrent symptoms has higher incidence of premature delivery. Nonrandomized studies have shown that laparoscopic cholecystectomy is preferred method of treatment over open cholecystectomy in pregnancy. Second trimester of pregnancy is the preferred time as foetal organogenesis is complete and uterus is still not very large. No significant differences in pre-term delivery rates, birth weights, or 5-min Apgar scores were found between open or laparoscopic cholecystectomy. No birth defects or uterine injuries occurred.

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REFERENCES