Celebrating 50 years of publishing

(Dr. Gross replies)

Thank you for allowing me to respond to Dr. Johnston. I agree with his observations about the wait-list as encountered now in Alberta. The essential question is, "was it always so?" Based on my own observations, I suspect that there is always variation in a wait-list, which can be managed by the individual surgeon. The longer the wait-list, the more unstable it becomes, and the more likely that patients will look elsewhere, surgeons will book patients expectantly and referring doctors will send patients sooner to get a spot on a long wait-list. Hence the need to get better data when deciding how to deal with a large and unreliable wait-list. The 1 constant in all of this is that orthopedic surgeons will continue to treat their patients according to a professional standard that puts need ahead of all other considerations. My worry is that devolving the responsibility of wait-list management to administrative algorithms driven by simple theories, such as the "queuing theory," interferes with that which is most important to the surgeon — the relationship with the patient.

Wait-lists increased as a result of a reduction in resources for elective surgical procedures, not because of an inherent problem with wait-lists as run by orthopedic surgeons. The most recent experience in British Columbia would suggest that restoring access to operating rooms dramatically reduces the wait-list. That is where I would prefer to see most of the resources directed in dealing with this problem.

Michael Gross, MD
Professor of Surgery,
Division of Orthopedics,
Dalhousie University;
Queen Elizabeth II Health Sciences Centre,
Halifax, NS.

Competing interests: None declared.

Intussuception in adults: surgical aspects

In regard to an article published in the February issue of the *Canadian Journal of Surgery*,[1] entitled "Surgical images: soft tissue. Transverse colonic intussusception," the authors should not have tried manual reduction, since a great percentage of the intussusceptions in adults (up to 65%)[2,3] has a malignant origin,[4] and manual reduction could cause a dispersion of the tumour. It is necessary to be sure that the lesion has no malignant origin, by sending a transoperatory histopathological test.

Invaginations in adults must be resected without attempting reduction. They are mostly of the ileocolic variety, and coloenteric anastomosis in either case has good results, any time a patient is under adequate intestinal preparatory preparation, despite being different from neoplasic pathology.

A.J. Montiel-Jarquín, MD
General Surgeon
Instituto Mexicano del Seguro Social,
UMAE,
Puebla, Mexico

Competing interests: None declared.

References

1. Correia JD, Lefebvre K, Gray DK. Surgical images: soft tissue. Transverse colonic intussusception. *Can J Surg* 2007;50:60-1.
2. Azar T, Berger DL. Adult intussusception. *Ann Surg* 1997;226:134-8.
3. Begos DG, Sandor A, Modlin IM. The diagnosis and management of adult intussusception. *Am J Surg* 1997;173:88-94.
4. Lorenzi M, Iroatulam AJN, Vernillo R, et al. Adult colonic intussusception caused by a malignant tumor of the transverse colon. *Am Surg* 1999;65:11-4.

Essential reading

from Canadian Medical Association

- *CMAJ*
- *Canadian Journal of Surgery*
- *Journal of Psychiatry & Neuroscience*

For information contact
CMA Member Service Centre
888 855-2555
cmamsc@cma.ca

Association médicale canadienne
Canadian Medical Association