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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Second-best prostatectomy?

SIR,—Your leading article entitled "Second-best prostatectomy?" (1 March, p 590) rightly reminds us that the results of prostatectomy by endoscopic resection are superior to those obtained by open methods except for the very large gland. But you are wrong in thinking that the surgeon who carries his share of the emergency work load of a district hospital and does the generality of surgery is incapable of achieving a high standard of endoscopic work for prostatic disease and bladder tumours.

Most patients with prostatic disease present themselves to district hospitals, and where there is a general surgeon with an interest in urology the large majority of them will be treated endoscopically and will be home in less than a week after operation. One-hundred-and sixty such surgeons exist in England and we are associate members of the British Association of Urological Surgeons. Together we deal with more prostatic disease in a year than the "pure" urologists and will probably continue to do so in the foreseeable future. We are very grateful for the teaching we receive from the specialised urologists and it is thanks to this teaching and the availability of modern resectoscopes that a mortality of less than 1%, a low morbidity, and short hospital stay can be achieved in district hospitals. We hope that the specialist urologists will continue to pass on their skills and encourage more general surgeons, especially those in training, to take an interest in urology.

It is to be hoped that with the help of the specialised urologists enough surgeons in training will discover the fascinations of urology and will combine it with general surgery to provide a "best-buy" prostatectomy service in district hospitals in the future, and that not too many of them will succumb to the blandishments of those who claim that urology and general surgery are mutually exclusive.

PETER BOREHAM

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SIR,—I read with interest the recent leading article entitled "Second-best prostatectomy?" (1 March, p 590).

I agree that transurethral prostatectomy performed by an expert is undoubtedly the best operation. You fail to realise, however, that outside teaching centres waiting lists for prostatectomy are long. Without the aid of surgeons in training and general surgical consultants who perform open operations the waiting list would become even longer.

Leach[1] reported an overall postoperative mortality of 2·3%. What this figure fails to disclose is that this mortality was not related to the type of operation performed. In patients under 70 years of age the mortality was only 1%—a very acceptable figure. Also the "54-year old man" you referred to died from mitral stenosis and did in fact have a transurethral resection of his prostate.

In an ideal world there would be a urologist in every district general hospital. They would, however, be largely underemployed. The alternative of transporting patients, who are often elderly and infirm, long distances to a specialist urological centre is illogical as well as expensive. Logistically the best alternative is that which we have at present, and which you deny exists, namely general surgeons with an interest in urology who, incidentally, are capable of treating "haematemeses and vascular catastrophes" while sharing the on-call with their colleagues.

MICHAEL HANCOCK

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[1] Leach RD. *Ann R Coll Surg Engl* 1979;**61**:459-62.

SIR,—Your leading article (1 March, p 590) "Second-best prostatectomy?" was a remarkable justification for urology as a specialty and