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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.

Proctoscopy and sigmoidoscopy

SIR,—I am sorry to see Mr D J Ellis and Mr P G Bevan perpetuating the myth that, to be effective, sigmoidoscopy needs to be carried out under general anaesthesia (9 August, p 435). I had the interesting experience of receiving my initial surgical training in a region where sigmoidoscopy was always carried out under general anaesthetic. The later years of my training were spent with two consultants, one a district hospital general surgeon, the other a specialist colorectal surgeon, both of whom routinely used outpatient sigmoidoscopy. My impression, though I have no figures to prove it, was that the latter method of examination was just as effective as the former and almost free of the risk of perforating the bowel.

Outpatient sigmoidoscopy with a rigid metal sigmoidoscope of the Welch Alleyn type is easy and convenient for both patient and surgeon. The sensitive rectosigmoid junction can usually be negotiated if the surgeon waits for a wave of peristalsis to reveal the lumen beyond, and if he forewarns the patient of the discomfort likely to be experienced at this point. Indeed the nature of the discomfort experienced at the rectosigmoid can provide useful diagnostic information. In those patients in whom the rectosigmoid cannot be negotiated a repeat examination at a later date, or examination with a flexible sigmoidoscope or an air contrast barium enema, will provide the necessary information. In patients who do need general anaesthetic for removal of polyps, etc, the correct sigmoidoscope to use is the larger operating variety.

I shudder to think of the effect on my lists and on the hospital budget if I admitted the 20 or so patients who undergo sigmoidoscopy in my clinics each week.

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SIR,—Mr D J Ellis and Mr P G Bevan (9 August, p 435) quite rightly emphasise that both proctoscopy and sigmoidoscopy should be preceded by a digital examination using the "lubricated forefinger." It is my contention, however, that one can adequately assess the anal canal only by first using the forefinger and then, if this is satisfactorily accepted, supplementing it with the passage of the adjacent mid-finger. Any normal, healthy anal canal will accept these two fingers (alongside each other) and the hand can be pronated to and fro to examine the passage in both planes. Inability to carry out this manoeuvre without discomfort indicates some degree of major or minor stenosis, be it spasm or organic fibrosis of the sphincter musculature. The passage of a solitary finger does not necessarily exclude these conditions. The inability to insert two fingers without causing pain indicates the need for dilatation. This may be by the repeated use of dilators or, if the condition is more severe, by internal sphincterotomy, pectenotomy, or manual dilatation as recommended by Lord.[1] I have found this "two-finger test" a most valuable adjunct to any clinical assessment of anal or rectal pathology and the planning of future management.

One minor point I would make is that successful proctoscopy depends on permitting air to enter the rectum through the opened proctoscope. This is much facilitated if a sandbag is placed under the left buttock and the patient partially rolled into a semi-prone or Sims position. In healthy young patients the knee-chest (not knee elbow) position is much to be preferred, but should be avoided in obese subjects and those with poor cardiovascular reserve. This position is also as a rule unacceptable to the female patient. Adoption of the right rather than the left lateral position may help in engaging a difficult rectosigmoid junction, although it may make greater demands on the dexterity of a right-handed examiner.

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[1] Lord P. *Proc R Soc Med* 1968;61:935-6.

SIR,—I think that your recent article in "Procedures in Practice" on proctoscopy and sigmoidoscopy (9 August, p 435) contained certain errors and omissions. General anaesthetic is not "usually needed" (your words) for complete visualisation of the rectum and lower sigmoid and the left lateral position