We read the above article with interest as we conducted a study titled “Endonasal dacryocystorhinostomy with and without stenting” by Syed et al. (NHS Lothian, UK) and a Cochrane review on the same topic. There were aspects in the paper that are unclear and leave us rather puzzled.

The authors state that all the cases were performed by the same surgeon but they did not state how the surgeon decided that stents were needed in a particular case and whether these stents were taken out or left in permanently.

Furthermore, the authors state that the group of patients without stents had a greater subjective success rate than those with stents but have given no logical explanation as to why the group of patients without stents had a significantly better outcome. This finding is in stark contrast to other studies including randomised controlled trials on the subject that reported no significant differences in outcomes between the two groups or even a slightly better outcome. This finding is in stark contrast to our paper. In the stented group, the stents were removed at three months following surgery. We believe that the authors draw from their study is based on unreliable data.

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AUTHORS’ RESPONSE
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We read the response by Syed et al to our study with interest and are surprised by the conclusions they have drawn from our paper.

It was stated clearly in our article that between 2002 and 2005 the senior author performed dacryocystorhinostomy (DCR) with a stent. As his success rate was lower than comparable evidence, he decided to change his practice in the hope of improving his results and performed DCR without a stent between 2005 and 2006.

Syed et al’s queries regarding stents (including removal time) have already been addressed in the methods section of our paper. In the stented group, the stents were removed at three months following surgery. We believe and understand that this is not premature as stent removal can vary from 4 to 24 weeks postoperatively.

As for Syed et al’s comment on higher subjective success in the non-stented group, it was stated clearly in our publication that the use of stents was associated with eye irritation, displacement of the tube at the medial canthus, nasal crusting and granulation formation at the rhinostomy orifice, which can affect the outcome. This has been supported by the literature in that a stent can be the reason...
for surgical failure owing to causing granulation tissue for-
mation, synechia formation and punctual erosion.2–4
Syed et al’s comparison of our study with contradictory
evidence in the literature including their own study seems
selective. There is clear evidence available in the literature
for and against the use of stents in DCR and this was
acknowledged in our introduction. Several studies (includ-
ing a prospective randomised study) show a higher success
rate in DCR without stents.2–9 Our study concluded that
stents are not necessary for primary DCR. This conclusion
has been supported by two meta-analyses.10,11
The postnasal blockage for our patients was tested by
the ophthalmologists, who used dacryocystography where
indicated. This was a very small group of patients and was
deemed too insignificant a finding to be elaborated on in
our article.

Generally, a retrospective power calculation is not
advised. It is not regarded as good practice and if the result
of a retrospective study is significant, power is of no inter-
est.12–14 It would appear that prospective power has been
confused with retrospective power. Depending on how ret-
rospective power is calculated, it might be legitimate to
use it to estimate the power and sample size for a future
study but it cannot be used legitimately as describing the
power of the study from which it is calculated.15

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LETTERS AND COMMENTS

Retained surgical sponges, needles and instruments

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I read with interest the review by Hariharan and Lobo in
which they discuss the incidence of retained surgical items
and the seriousness of outcomes to patients, particularly
when sponges are retained. Clearly, this issue has not been
resolved and requires attention. The authors rightfully
point out that the surgical count, a primary preventive
measure, has limitations. Discrepancies in the count are a
common event and the sensitivity of the surgical count is only
77%.1 We conducted a healthcare failure mode and
effect analysis that identified potential failures in the pro-
ceses of preventing retained sponges.2 Distraction and mul-
titasking were the most frequent causes, and are especially
difficult, if not impossible, to eliminate.

In their algorithm, Hariharan and Lobo propose using a
standardised count process, the surgeon confirming the final
count, and the use of radiography if the surgical count is
incorrect. This poses a challenge clinically. In addition to the
limitations of the count, the sensitivity of intraoperative
radiography for detection of a retained surgical item is only
67%.3 If we rely on these two interventions, we will not likely
eliminate retained surgical items. The more sensitive postop-
erative survey images are taken outside of the operating the-
atre. This would require tremendous expense and a return
trip to theatre if an item is identified. The algorithm would
be enhanced by including methodological wound exploration
by the surgeon, to search for sponges prior to closure, and a
hard stop when a count is reported as being incorrect.

We should also comprehensively evaluate adjunct tech-
nology. There are currently three adjunct technologies available to supplement the current processes for preven-
tion of retained sponges. Hariharan and Lobo provide a
comprehensive review of the evidence regarding two: the
barcoded counting system and the radiofrequency identifi-
cation system. The third, a radiofrequency (RF) detection
system, involves low energy RF chips sewn into sponges
and a scanner for detection of the sponges. Two scanners
are available: a wand that is passed over the patient and a
mat that is placed under the patient.

Studies have found the sensitivity and specificity of the
RF wand to be 100%, even in morbidly obese subjects.4,5
The mat is slightly less sensitive for detection in morbidly
obese than in non-morbidly obese patients (97% vs 100%).5

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