page 71. In fact, I sited both of Dr. Pelosi’s important articles (Pelosi MA II, Pelosi MA III. Hand-assisted laparoscopy for complex hysterectomy. *J Am Assoc Gynecol Laparosc.* 1999;6(2):183–188) and (Pelosi MA II, Pelosi MA III, Hand-assisted laparoscopic cholecystectomy at cesarean section. *J Am Assoc Gynecol Laparosc.* 1999;6(4):491–495). For whatever reason, when the original paper was split into 2 separate papers, Dr. Pelosi’s citations went with the second paper. It was my intention that the 2 papers would be published together. However for reasons beyond our control, they were published a few months apart.

In the end, our references are correct in the technique paper that Dr. Pelosi refers to. The article is not intended to be a comprehensive review of the literature but serves as a reminder to our fellow gyn colleagues about the value of this technique. I believe that both of these articles validate a topic that Dr. Pelosi has written about in the past. Our article is complementary to Dr. Pelosi’s and recognizes his contributions. Now, nearly 4 years after the start of this project, with the increased adoption of robotic surgery, I fear the familiarity of the HALS modality in gynecology may diminish. Although I regret any offense Dr. Pelosi may have taken, I am glad we are able to keep the dialogue going and continue to bring awareness to HALS in our gyn community.

Sincerely,
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**Re: *JSLS*(2009)13(3):346–349. Long-term Study of Port-site Incisional Hernia After Laparoscopic Procedures**

Dear Editor,

We read the article written by Hussain et al with interest. In our recent experience, we have seen 5 epigastric port-site hernias. All procedures were performed by different laparoscopic surgeons. We use 1 of 3 methods in closing 10-mm ports to prevent the formation of port-site hernia. They are sheath tilt, Langenbeck’s lift, and Sucker through port techniques. It is universally agreed that the closure of the port site should include approximation of the sheath. We have described the sheath tilt and Langenbeck’s lift previously. For epigastric port sites, we found the 10-mm sheath tilt requires a slight extension of the skin incision to access the sheath. We use a third method, which we call the “Sucker through port” method. In this method, the sucker for irrigation is inserted to the 10-mm port, and the sheath is pulled out. By tilting the sucker and simultaneously retracting the skin with a medium Langenbeck’s retractor, one can visualize the sheath clearly. By tilting the sheath on either side, one can take a full-thickness bite of the sheath. Care should be exerted when inserting the suction cannula to ensure that it is not inserted too deeply to avoid damage to intestinal viscera. We always close the 10-mm ports, in particular all epigastric ports, with a 0 PDS J needle. We have not come across a single case of port-site incisional hernia even after several years of surgical practice.

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**References:**

1. Hussain A, Mahmood H, Singhal T, Balakrishnan S, Nichols J, El-Hasani S. Long-term study of port-site incisional hernia after laparoscopic procedures. *JSLS* (2009)13(3):346–349.
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Author’s Response

Dear Colleagues:

Many thanks for your interest in our article. We should congratulate you for your excellent results that you “have not come across a single case of port-site incisional hernia even after several years of surgical practice.”

Having said that, you are closing the 10-mm port using 3 different techniques (sheath tilt, Langenbeck’s lift, and Sucker through port techniques). It would be interesting to know what type of and how many operations you have done, and also how many obese patients and how many children were included.

The major inherent weakness of reporting on the hernia issue is the follow-up. The longer the follow-up the higher would be the incidence of hernias. Studies from respected centers in the world have confirmed this.1

The other issue is that sometimes surgeons do not see their complications, because their patients present to other colleagues. We too have operated on patients who underwent surgery somewhere else, and also you mentioned that you operated on several patients who were operated on by other surgeons.

On top of that is the iceberg phenomenon, as we may not see patients with subclinical hernia (especially in the obese), because they are not symptomatic or they are not seeking medical help.

The last issue is the controversy in reporting cross-sectional imaging of patients who present with symptoms suggestive of port-site hernia.

It is mandatory to close the 10-mm port. We also close 5-mm ports in kids. A recent study2 had a confirmed incidence of 3.2% of port-site hernias in children who underwent laparoscopic procedures. Needless to say, 5-mm ports can be potential hernia sites, especially in elderly frail patients and thin and malnourished patients.

We totally agree with you that refining the closure techniques or invention of new methods is crucial to reducing the catastrophic accidents of port-site incisional hernia.3

Regards,
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1. Hawn MT, Snyder CW, Graham LA, Gray SH, Finan KR, Vick CC. Long-term follow-up of technical outcomes for incisional hernia repair. J Am Coll Surg. 2010;210:648–657.

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3. Reardon PR, Preciado A, Scarborough T, Matthews B, Marti JL. Hernia at 5-mm laparoscopic port site presenting as early postoperative small bowel obstruction. J Laparoendosc Adv Surg Tech A. 1999;9:523–525.

Re: JSLS(2009)13:302–305. Improved Outcomes for Lap-banding Using the Insuflow Device Compared with Heated-only Gas

Dear Editor,

We read with interest the recent paper by Benavides et al1 and commend the authors for conducting a double-blinded, randomized trial of this nature. There are very few high-quality trials evaluating warming and humidification of laparoscopic insufflation gas.2,3

The authors indicate that the surgeon and principal investigator were blinded to patient allocation. However, the method of blinding was not outlined. It is clear from the paper that a different insufflation tube was used, depending on whether the patient received dry cold gas, heated only gas, or humidified warm gas. Therefore, how was blinding of the tubing achieved during the operation? Who was responsible for setting up the equipment, and was this done away from the view of the surgical team?

Secondly, we would like to indicate that there appears to be a potential conflict of interest on the part of the journal, as one of the associate editors has patented the device in question (Insuflow® gas conditioning system) and has a previously disclosed financial relationship with the manufacturer. We suggest that this should be indicated in the