

synaptic cleft, especially when combined with an agent which inhibits serotonin reuptake. The reaction with venlafaxine is consistent with reports of the serotonin syndrome occurring with combined intake of moclobemide and selective serotonin reuptake inhibitors.³

- 1 Brubacher JR, Hoffman RS, Luslin ML. Serotonin syndrome from venlafaxine-tranylcypromine interaction. *Vol: Hum Toxicol* 1996; 38: 358-361.
- 2 LoCurto MJ. The serotonin syndrome. *Emerg Med Clin North Am* 1997; 15: 665-675.
- 3 Benazzi F. Serotonin syndrome with moclobemide fluoxetine combination [letter]. *Pharmacopsychiatry* 1996; 29: 162. □

The risk of venous thrombosis following gynaecological laparoscopic surgery

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To the Editor: The finding by Patel et al¹ of a 55% rate of asymptomatic lower limb venous thrombosis following laparoscopic cholecystectomy led us to repeat the study in patients having gynaecological operative laparoscopy.

This was a prospective observational study set in a private hospital, using a private ultrasound department. The women enrolled were having an operative laparoscopic procedure with no other major operations. Each completed a questionnaire assessing risk factors for deep venous thrombosis, and each had three duplex ultrasounds of the veins of the lower limbs (pre-operation, 1 to 3 days post-operation, and 7 days post-operation). The duplex ultrasounds were performed on an Acuson XP10 (Acuson Corporation, Mount View, CA, USA), using the same protocol as Patel et al.¹ We also assessed the iliac vessels and

inferior vena cava to the level of the diaphragm, using an abdominal transducer. If a woman was opened at operation or did not complete three duplex ultrasounds, she was excluded from analysis. A power calculation, based on an expected maximum venous thrombosis rate of < 1%, indicated that 13 subjects would show a significant difference from Patel et al's study ($P < 0.05$, power = 80%).

Of the 26 women enrolled in the study, one was converted to open myomectomy and five did not complete all three duplex ultrasounds. The remaining 20 women were included in the analysis. Their mean age was 36.6 years (see Box) and none had a history of malignancy or previous thrombosis. Five were smokers, three had varicose veins and three had had a recent infection. The mean length of operation was 73.5 minutes. The operations were excision of endometriosis (9), diagnostic laparoscopy (4), hysterectomy (3), colposuspension (2), bilateral salpingectomy (1), and adhesiolysis (1). All patients had intraoperative calf stimulators, and none had preoperative or postoperative thromboprophylaxis.

No thrombosis was found in any of the 20 women (or in the six excluded from analysis). This finding (0/20; 95% confidence interval, 0-0.17) is significantly different ($P = 0.0003$) from the findings of Patel et al (55% [11/20]).

Laparoscopic procedures have previously been found to carry a low risk of thromboembolic disease (0-0.4%).^{2,4} Our study's findings agree with this. Gynaecologists can be reassured about the low risk of lower limb venous thrombosis in gynaecological operative laparoscopic procedures.

Differences in patients and procedures between this study and that of Patel et al are summarised in the Box. Factors that may increase the risk of lower limb venous thrombosis in laparoscopic cholecystec-

tomy include the head-up position (lower limb venous pooling) and more advanced age (55.5 versus 36.6 years). Further work is needed to see if the findings of Patel et al can be duplicated.

- 1 Patel MI, Hardman DTA, Nicholls D, et al. The incidence of deep venous thrombosis after laparoscopic cholecystectomy. *Med J Aust* 1996; 164: 652-656.
- 2 Cavaye D, Kelly AT, Graham JC, et al. Duplex ultrasound of lower limb deep venous thrombosis. *Aust N Z J Surg* 1990; 60: 283-288.
- 3 Peterson HB, Hulka JF, Phillips JM. American Association of Gynecologic Laparoscopists' 1988 membership survey on operative laparoscopy. *J Reprod Med* 1990; 35: 587-590.
- 4 Querleu D, Chevallier L, Chapron C, Bruhat MA. Complications of gynaecological laparoscopic surgery: A French multicentre collaborative study. *Gynaecol Endosc* 1993; 2: 3-6. □

Intrauterine pregnancies following laparoscopic tubal reanastomosis

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To the Editor: We were interested in the recent report on laparoscopic tubotubal reanastomosis¹ and can confirm that the technique is eminently feasible. Our first such patient, a 37-year-old woman, has since given birth to a live infant.

She had a laparoscopic clip sterilisation performed in 1992 after the birth of her third child and immediately experienced deep regret, which persisted despite appropriate counselling. In 1994, her obstetrician removed the Filshie clips laparoscopically, but the fallopian tubes were not reconstructed. She was then referred for tubal reconstruction.

A recent report from Sweden² describing a laparoscopic procedure was discussed with the patient, she chose this option and was admitted as a day case in October 1996.

Fallopian tube reconstruction was performed as a single-layer laparoscopic technique, identical to that described by St George et al,¹ except that 4/0 Prolene sutures, rather than Liga clips, were applied to the broad ligament.

At review two months later the patient was well and the laparoscopy port scars had healed. She returned in May 1997 for review and to indicate that she now wished to conceive, as that was the only way she would be satisfied that she was once again a normally "intact" female. She was encouraged that all was normal, and a mid-luteal serum hormonal assessment indicated that ovulation was taking place during that cycle. Her next menstrual period occurred on 13 June 1997, and she conceived in the following cycle.

Comparison of patients undergoing laparoscopic procedures in two studies

Factor	Patel et al ¹	Present study
Patient sex	Male and female	All female
Mean patient age (range)	55.5 years (30-83)	36.6 years (24-47)
Operation	All laparoscopic cholecystectomies	Various gynaecological operative laparoscopic procedures
Mean length of operation (range)	80 minutes (40-160)	73.5 minutes (15-160)
Thromboprophylaxis	80% calf stimulators, 95% subcutaneous heparin	100% calf stimulators
Patient position	Head-up	Steep Trendelenberg (head-down)
Number with deep venous thrombosis	11/20	0/20

We believe the laparoscopic-reversal technique is relatively easy to perform for those who have the basic skills for laparoscopic suture tying. As with most gynaecological procedures nowadays, we believe that laparoscopic techniques have virtually taken over from the open approach. As reversal of sterilisation is no longer being reimbursed by Medicare, patients will be seeking the less expensive option, particularly if, as appears to be the case, the procedure is equally effective.

1. St George LI, Kapila HB, Lahoud RH. Laparoscopic tubotubal reanastomosis. *Med J Aust* 1997; 167: 367-368.
2. Dubuisson JB, Swolin K. Laparoscopic tubal anastomosis (the one suture technique) preliminary results. *Hum Reprod* 1995; 10: 2044-2046. □

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To the Editor: I read with interest the recent article describing laparoscopic fallopian tube reanastomosis.¹ I have now performed six bilateral tubal reversals, between August 1995 and October 1997. Of the first five women, three have since delivered normal infants at term.

In the first five women, reanastomosis on each side was performed with three or four 6/0 Prolene sutures passed through the muscularis and secured with intracorporeal knots. For the sixth patient, 8/0 Prolene sutures were used, with specialised laparoscopic microsurgical instruments. The mean operating time was 136 (range, 120-180) minutes. The postoperative course was uneventful in all patients; three were discharged on the day of surgery, two stayed overnight because of drowsiness, and one patient, who also had colposuspension performed, was discharged on Day 2.

Since the first report of laparoscopic tubal reanastomosis, in 1989,² various minimal-access techniques have been proposed, including sutures, tissue glues, clips, combined hysteroscopic and laparoscopic approaches, and combined laparoscopy and minilaparotomy. Early reports suggest a pregnancy rate similar to the 60%-80% expected for open surgery.³ If the tubes are realigned adequately and sufficient tubal length remains, there should be no difference in outcome between a minimal-access approach and the traditional laparotomy. Indeed, the benefits of minimal tissue handling and drying may have a significant

effect on subsequent adhesion formation and thus success rates.

New developments in clip technology (such as staples now being designed for endoscopic coronary artery bypass grafting) may ultimately enable a sutureless procedure. Similarly, developments in tissue glues may enable the reanastomosis to be performed over some form of temporary stent. Combined laparoscopy and minilaparotomy may have a role, but not if there are significant anatomical distortions, particularly from previous surgery, or if tubal length is minimal.

I concur with St George et al that minimal-access tubal reversal following sterilisation is feasible, although difficult. Further advances in technique and instrumentation may facilitate the procedure.

1. St George LI, Kapila HB, Lahoud RH. Laparoscopic tubotubal reanastomosis. *Med J Aust* 1997; 167: 367-368.
2. Sedbon E, Delajolineres JB, Boudouris O, Madelenat P. Tubal sterilization through exclusive laparoscopy. *Hum Reprod* 1989; 4: 158-159.
3. Yoon TK, Sung HR, Cha SH, et al. Fertility outcome after laparoscopic microsurgical tubal anastomosis. *Fertil Steril* 1997; 67: 18-22. □

Local impact of the NHMRC early breast cancer guidelines

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To the Editor: Referring to the consumer version of the *Clinical practice guidelines for the management of early breast cancer*, Dunsis raises the point that the process of developing guidelines must include evaluation of the dissemination process and efficacy for users.¹ Of concern is her perception that some consumers may feel "overwhelmed, frightened or confused" by the statistics presented.

The consumer guide is an effort by the National Health and Medical Research Council (NHMRC) to provide evidence-based information to assist consumers in decision-making.² The document does not attempt to ensure treatment compliance or to dissuade women from using "alternative" therapies.

The guide was developed under the auspices of the Women's Subgroup of the NHMRC Early Breast Cancer Working Party, which includes consumers, women's health advocates and health professionals. A review of all available consumer literature about women's experiences with breast cancer underpinned the approach taken,

and indicated that statistical information was integral to women's information needs. Feedback from national consultative meetings conducted before the guide's release supported the style and format of the document. In particular, women appreciated access to "real data" rather than a watered-down version.

The National Breast Cancer Centre (NBCC) is responsible for disseminating the consumer guide, and is currently conducting a survey of women's perceptions, including their acceptance of and reactions to the guide. The NBCC has developed other resources for women, including *All about early breast cancer*,³ which has a lower reading age than the original consumer guide, and the acceptability of this is subject to the same rigorous evaluation.

Many women reading information about breast cancer will be distressed. Clearly, the method of communicating information may affect their responses, and this should be subject to ongoing scrutiny. However, bad news cannot be turned into good news, and any distress experienced should not be attributed to a document when it is the nature of the disease, its course and treatment that should be the focus of discussion.

1. Dunsis A. Local impact of the NHMRC early breast cancer guidelines. Where to from here? [letter]. *Med J Aust* 1998; 168: 141.
2. National Health and Medical Research Council. Early breast cancer: A consumer's guide. Canberra: AGPS, 1995.
3. National Health and Medical Research Council. National Breast Cancer Centre. All about early breast cancer. Sydney: The Centre, 1996. □

Trends in asthma mortality in Australia, 1960-1996

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To the Editor: Analysis of recent figures from the Australian Bureau of Statistics shows that asthma mortality rates in Australia in the five to 34 years age group are now at their lowest level since 1960 (Figure). Between 1995 and 1996, annual deaths from asthma fell once again, from 749 to 730 overall and from 50 to 47 for people aged five to 34 years. This continues the downward trend in asthma mortality that has been evident since the late 1980s.

In contrast, a report from the National Health and Medical Research Council (NHMRC) 10 years ago showed that deaths caused by asthma had been increasing since 1978, and that observed rates in 1986 were higher than in most comparable countries.¹ This report also suggested that