

The Editors welcome topical correspondence from readers relating to articles published in the Journal. Responses should be sent electronically via the BJS website (www.bjs.co.uk). All letters will be reviewed and, if approved, appear on the website. A selection of these will be edited and published in the Journal. Letters must be no more than 250 words in length.

Multicentre observational study of the natural history of left-sided acute diverticulitis (*Br J Surg* 2012; 99: 276–285) (*Br J Surg* 2012; 99: 285–286)

Sir

We have read the invited commentary to our article¹ by Dr Flum. He is an authority in the field and we greatly appreciate his views. The sources of inaccuracy he raises, including patients lost to follow-up or uncertainty regarding the proportion of emergency operations, are indeed very real difficulties inherent in any study of this sort. We deal with these in the discussion, but nevertheless we believe that the study has produced new data despite these limitations.

Dr Flum mentions that only recurrences requiring admission to hospital were included. One of the most important aspects of the study was that all patients were diagnosed according to the most objective criteria possible in clinical practice. Thus we defined acute diverticulitis (AD) by clinical and radiological criteria; recurrence as a new episode of AD was diagnosed according to the same definition and had to occur at least 2 months after complete resolution of the index episode. Patients with radiological evidence of acute diverticulitis were rarely treated as outpatients. Some patients treated with antibiotics for abdominal pain and fever in an outpatient setting without instrumental examination confirming the diagnosis of AD were simply classified as having persistence or recurrence of symptoms. It is of course the case that a multicentre study of diverticular disease as presented in our study is extremely difficult to carry out. Confounding factors include the accuracy of data recording,

uniformity of adherence to the protocol, and variation in the clinical severity of the illness, length of follow-up and many other variables. Any future study will always be faced with the same practical difficulties to a greater or lesser extent.

Despite these difficulties, we are, nevertheless, strongly of the view that the data presented represent an advance on previous studies. Admittedly, the results do not give a complete picture but they add to present knowledge beyond what was available before.

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- 1 Binda GA, Arezzo A, Serventi A, Bonelli L; Italian Study Group on Complicated Diverticulosis (GISDIC). Multicentre observational study of the natural history of left-sided acute diverticulitis. *Br J Surg* 2011; 99: 276–285.

Late results of endoscopic thoracic sympathectomy for hyperhidrosis and facial blushing (*Br J Surg* 2011; 98: 1719–1724)

Sir

We compliment Drs Smidfelt and Drott for their excellent and very important publication. This is the only long-term thorough follow-up of endoscopic transection of the sympathetic chain over the ribs (ETS) for primary hyperhidrosis and blushing, their series being the largest ever reported. Compensatory sweating remains the major sequela of ETS, its pathophysiology is obscure, and no satisfactory solution exists. It has been suggested that lowering the level and/or reducing the extent of ablation might reduce this complication, but this is controversial and remains a matter of debate¹.

In this series, different levels of ablation have been used for treatment of similar areas of excess sweating. A specific analysis of the results for each level could supply important information about the correlation between the level of ablation and the outcome of surgery, both in terms of compensatory sweating and long-term success. The authors probably possess these important data. Analysis and publication could have a great impact on the worldwide performance of ETS, so we would very much appreciate further details.

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- 1 Kopelman D, Hashmonai M. The correlation between the method of sympathetic ablation for palmar hyperhidrosis and the occurrence of compensatory hyperhidrosis: a review. *World J Surg* 2008; 32: 2343–2356.

Authors' reply: Late results of endoscopic thoracic sympathectomy for hyperhidrosis and facial blushing (*Br J Surg* 2011; 98: 1719–1724)

Sir

We agree that compensatory sweating remains the major sequela after endoscopic thoracic sympathectomy. An analysis of whether the level and extent of denervation had an impact on the degree of compensatory sweating was made. There was no significant overall

correlation, but a tendency towards less compensatory sweating with less extensive denervation. Subgroup analysis was also performed but, because the level and extent of denervation differed between indications and to some extent between surgeons and also changed over time, we were unable to draw any firm conclusions from the existing data. Prospective randomized studies are needed to answer this important question.

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Surgical wisdom (*Br J Surg* 2012; 99: 3–5)

Sir

Gruen and colleagues quote Aristotle's ideas on 'practical wisdom', which teach us that wisdom has an intellectual and moral base, and is acquired through guided experience, time and habit. The striking question raised (but not addressed) in this paper is how we develop wisdom during our professional life, and perhaps more importantly how we nurture this process in young doctors for whom we have educational responsibility. The technical approach to assessment currently prevalent in postgraduate medical education falls far short on this matter.

We have, over the past 10 years, been developing and using resources for teaching and learning in the clinical setting aimed at cultivating professional wisdom. Our approach, refined with colleagues in real clinical practice, based

on Aristotle, uses *The Invisibles*^{1,2} and in particular the clinical thinking pathway, as a language and a framework for reflective exploration, both orally and in writing, of a clinician's clinical reasoning and deliberation.

We have shown that, through our process of clinical reflective writing³, doctors are able to understand themselves and their decision-making in greater depth, and in a way more meaningful to their everyday practice. Such writing enables them to refine, record and store evidence of their professional progress and developing expertise and wisdom. We have found that teachers and learners are profoundly surprised by what is learned through this process and how it acts as a motivator for development. An evaluation of this, from the experiences of 11 senior clinicians, will be published early in 2012.

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- 1 de Cossart L, Fish D. *Cultivating a Thinking Surgeon*. TFM Press: Shrewsbury, 2005.
- 2 Fish D, de Cossart L. *Developing the Wise Doctor*. RSM Books: London, 2007.
- 3 Ed4MedPrac. <http://www.ed4medprac.co.uk> [accessed 19 March 2012].

Authors' reply: Surgical wisdom (*Br J Surg* 2012; 99: 3–5)

Sir

Becoming wise requires insight and self-reflection. As we state in our con-

ception of surgical wisdom 'rich understanding comes from thinking about things deeply'. De Cossart and Fish advocate the value of reflection and reflective writing, a learning strategy in which they have provided great leadership. We agree that these strategies can have a positive role in clinical practice and in the cultivation of wisdom.

However, wisdom requires more than reflection alone. One must first start to practise, as wisdom grows with experience and time, is determined by choice and acquired by habit. Wisdom is much more than reflecting on past performance – it is about making good forward-looking decisions, and the ability to proceed and progress in the face of uncertainty. One will not become wise by navel gazing; wisdom is attained by first being competent and professional, then exhibiting superior judgement, a rich understanding, holding few unjustified beliefs, and having a strong moral compass. This is the pathway we spelled out for becoming wise. There is no formula for actually doing this – it is a long journey. Although reflection can provide useful self-monitoring and feedback, it is only one aspect of the broad tapestry that constitutes wisdom.

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