of IS than one would normally expect, especially given that the majority of IS followed medical admission rather than operations or invasive procedures. Additionally the number of IS may be influenced by the fact that the study site is a tertiary centre for oncology and cardiothoracic surgical services and our data certainly reflects this. Conversely the study site does not have on-site neurosurgical services so some cases may be transferred to another site for neurosurgical input and not recorded in the HIPE database. This may partially explain the low rates of haemorrhagic stroke seen in the study. Despite the absence of delay to presentation, previous studies have shown that assessment for thrombolysis can take longer in IS compared to OS[8]. While protocols are often in place to streamline acute stroke management in the ED this is often not the case in the inpatient ward setting, potentially creating unnecessary delay in acute care. Also, nursing and other care staff on surgical or general wards are less likely to be experienced in the recognition of early stroke signs and provision of acute stroke care.

While intravenous thrombolysis may be contraindicated in the post-operative setting, and almost 50% of the IS group were post-operative, intra-arterial options such as thrombectomy may present an alternative method for revascularization[9]. Enhanced awareness of, and access to, such services may impact positively on thrombolysis rates in this cohort. In the context of the Irish health service, currently acute strokes are often redirected away from smaller hospital EDs to permit acute interventions and stroke unit care. These hospitals will continue to have in-hospital strokes however and it is unclear whether they have the expertise or capacity to manage these patients. Perhaps there may also be a role for redirecting IS in a similar manner, or for the development of standardized protocols and policies for optimal management. Efforts should be made to optimize identification of acute stroke in this cohort and enhance care for patients post in-hospital stroke with the aim of improving outcomes in this group.

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Mouth, Head & Neck Cancer Awareness Campaign

Sir

A campaign to promote awareness of mouth, head and neck cancer in Ireland began in 2010. This campaign was initiated primarily by a group of cancer survivors, the Irish Dental Health Foundation, Irish Cancer Society and the university dental schools in Cork and Dublin. The first Mouth Cancer Awareness Day (MCAD) was held at the Cork and Dublin Dental University Hospitals in September 2010. In order to make the free examinations more accessible throughout the country, the Irish Dental Association became a partner in the campaign in September 2011.

The objective was to further increase awareness in the general public and the dental profession. To date, 70% of dental practices countrywide have offered free mouth cancer examinations in addition to the two dental schools in 2010, '11, '12 and '13. Mouth, Head & Neck Cancer Awareness Ireland (MHNCAI) has promoted increased public and professional awareness of the warning signs of this disease, stressing the importance of early referral for these patients. We, of course, stress that a check for changes in the oral soft tissues is provided at every dental visit but increased awareness in the public arena means that individuals seek help early. Self examination is also encouraged and supported. Early detection of mouth cancer will result in better treatment outcomes - early detection saves lives. On MCAD, mouth cancer check-ups and information are provided free of charge in dental practices around the country. The two Dental Hospitals, as well as providing check-ups, have provided support and immediate follow-up for any cases considered to be urgent by the examining dentists. As a result of this campaign, we have established a clear referral pathway. Since the campaign began, approximately 20,000 free examinations have been carried out and 22 cases of oro-pharyngeal cancer have been detected. More importantly perhaps, awareness of this 'Cinderella cancer' has been significantly increased in the general public and in the dental profession. The challenge now is to increase awareness in the medical and other healthcare professions. The favourable media response, which has been the oxygen of this campaign, has been a very important part of the success of this initiative. The partnership is convinced that an awareness day, rather than a week or a month, has been a key factor in attracting media coverage. Recent statistics indicate a rise in the incidence of mouth, head and neck cancer in the UK.

In September 2013, a number of dentists in the UK participated in Mouth Cancer Awareness Day and we made our data collection and information material available. Our experience in Ireland has

Table 1 Mouth Cancer Awareness Days (MCAD) in Ireland 2010 - 2013

	2010	2011	2012	2013	Total
Patients examined in Dublin Dental University Hospital	1660	435	Referrals from GDP	Referrals from GDP	2095
Patients examined in Cork Dental University Hospital	1340	568	301 MCAD and Referrals from GDP	404 MCAD and Referrals from GDP	2613
Patients examined in General Dental Practice	NA	6764	4460 (701 gdp registered)	3758 (602 gdp registered)	14,982
Urgent referrals *	123	Urgent 83 *GDP referrals	Urgent 23 *GDP referrals	Urgent 80 *GDP referrals	
Biopsy completed	32	18	7	9	76
Cancer diagnosed	6	13	2	1	22

*NOTE: Urgent referrals are recorded as patients seen in DDUH & CDUH and patients referred to DDUH & CDUH on the emergency phone line immediately following the MCAD. Further GDP referrals were received by various clinicians via multiple pathways over a protracted period of time and it was not possible to accurately track these referrals as related to the MCAD.

shown that this campaign has not only saved lives and increased awareness about this disease but has also highlighted the important role of the dentist as oral physician. The most recent MCAD (Ireland) was on Wednesday 17th September 2014. There were three new cancers diagnosed in the Dublin Dental University Hospital and these are being treated.

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The Critical View of Safety in Laparoscopic Cholecystectomy: Towards A National Consensus

Sir,

Laparoscopic Cholecystectomy (LC) is one of the commonest operations performed by surgeons today. Despite the decreasing incidence of bile duct injury (BDI) since the introduction of LC, it still remains a major complication today[1]. The commonest cause of BDI is misidentification of the anatomy of Calot's Triangle. A technique of identification of this anatomy, called the critical view of safety (CVS), was first described by Strasberg et al. in the mid-nineties and has been shown to significantly reduce the incidence of BDI[1-3]. Despite its success, it has failed to gain universal acceptance and the infundibular approach to dissection is still being taught today.

Currently in Ireland, there are no national guidelines or protocols in place for performing or training laparoscopic cholcystectomy. This prompted us to carry out an anonymous postal questionnaire in order to determine the level of anatomical knowledge and application of the CVS among Irish general surgeons. The questionnaire was sent to all general surgeons practising in the Republic of Ireland (N=187). We received 95 completed questionnaires which represented a response rate of 51%. Of the 95 responders, 91% (n=86) perform laparoscopic cholecystectomy. From this group, 80% (n=69) perform emergency or urgent LC and 55% (n=47) perform more than 50 LC's per year. When performing LC, the critical view of safety was the sole method used by 31% (n=27) of surgeons, 2% (n=2) of surgeons use the infundibular approach alone, 54% (n=46) use both techniques and 13% (n=11) use neither technique. Surgeons who did not use either technique and were involved in training surgical residents accounted for 12% (n=10) of the group. Finally, those who do not use either technique and perform emergency/urgent LC's accounted for 12% (n=10) of the total.

These results represent a "snapshot" of the anatomical approaches currently used and taught by general surgeons in Ireland when performing laparoscopic cholecystectomy. While the majority of surgeons (n=73, 85%) practice either technique or both, it is worrying that 13% (n=11) do not use or understand either technique. It is also significant that while 82% (n=64) demonstrate the CVS when training surgical residents there are 5% (n=4) who teach the infundibular technique alone and 13% (n=10) who teach neither technique. Current literature advocates the critical view of safety as the most effective method of reducing morbidity and mortality associated with laparoscopic cholecystectomy[2,3]. Recent practice guidelines by the European Association of Endoscopic Surgery (EAES) recommended the critical view of safety as the most effective approach to prevent BDI[4]. Despite this there are currently no national guidelines or protocols in place with regard LC. We believe the CVS approach to LC should be integrated into national guidelines and should be mandatory, in particular in training of surgical residents.

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