by any residual bleeding points, these are caught with the fine forceps and, using a low diathermy current, are coagulated. At this stage one proceeds to the opposite eyelid and at the end of the same surgery on this side, one returns to the original side to coagulate any possible bleeders to ensure complete haemostasis. Finally, excess skin is excised and the skin margins are sutured.

Only occasionally do patients complain of pain when the fat is being removed and their remonstrations are momentary while the diathermy is being used. It is interesting that skin anaesthesia alone suffices for this procedure and my experience confirms that of Dr N. Robbe in his letter to the Editor (*British Journal of Plastic Surgery*, **40**, 107).

The use of haemostats for grasping the base of the pad of fat is avoided for fear of causing traction on the deeper feeding vessels.

Perhaps these few remarks may be of interest to your readers.

Yours faithfully
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The significance of incomplete excision in patients with basal cell carcinoma

Sir

Richmond and Davie's article appearing in the January number (*British Journal of Plastic Surgery*, **40**, 63) confirmed all of the findings in our paper (Taylor, G. A. and Barisoni, D. Ten years' experience in the surgical treatment of basal cell carcinoma. *British Journal of Surgery*, 1973, **60**, 522). I assume that the authors' omission of our article from their otherwise appropriate list of references was a simple oversight.

I would commend our article to them as one of the first attempts to correlate various factors, including the presence of residual tumour in the margin of the resected specimen, with recurrence. Since our article appeared various authors, most of whom are mentioned in Richmond's reference list, have attempted to establish guidelines upon which management of these difficult cases can be based. My philosophy of management is still based upon the conclusions which appeared in my 1973 article and heretofore I have seen nothing in the literature, including the article in question, which would encourage me to change that philosophy.

Yours sincerely
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Reply from Mr Richmond

Sir

I first read G. Allan Taylor's paper whilst preparing my own: its omission from my "otherwise appropriate list of references" was, however, not an oversight.

Dr Taylor reviewed various factors which affect recurrence after surgery for basal cell carcinoma. The problem of incomplete excision is indeed discussed but in over half of his patients the pathology reports did not state whether or not the tumour had been completely excised: in those where excision was known to be incomplete it was not stated which margins were involved. The importance of this information and its possible role in determining further therapy was dismissed as "... such an approach is neither possible nor practical in the majority of centres". It is also difficult to know what was considered as "recurrent disease" as the paper in question states "Lesions appearing many months or years after removal can hardly be called recurrent".

My own paper was a review of cases known to have been incompletely excised and looked at the influence of various factors on the likelihood of recurrence and time taken for the recurrence to become clinically manifest. In addition, problems of offering supplementary treatment at that stage were discussed.

In short, the omission of G. Allan Taylor's paper from my bibliography was intentional. Little in the paper was of direct relevance to my own review—and the areas which were germaine were better documented in the papers which were cited.

Yours faithfully
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