resectable and non-resectable liver metastasis (data not shown).

Conclusion

The current study showed that our simple and low-cost regular surveillance programme after curative resection of colorectal adenocarcinoma results in acceptable resectability rates for liver metastasis and acceptable cancer-related survival. Further prospective studies are required to determine the optimal frequency and mode of surveillance, with a view to improving the resectability rate of liver-only metastases and overall patient survival.

References

1. Hong Kong Cancer Stat 2004. Hong Kong: Hong Kong Cancer Registry, Hospital Authority; 2007.
2. Jatzko GR, Lisborg PH, Stettner HM, Klimpfinger MH. Hepatic resection for metastasis from colorectal carcinoma—a survival analysis. Eur J Cancer 1995;31A:41-6.
3. Arriola E, Navarro M, Parés D, et al. Imaging techniques contribute to increased surgical rescue of relapse in the follow-up of colorectal cancer. Dis Colon Rectum 2006;49:478-84.
4. Pfister DG, Benson AB 3rd, Somerfield MR. Clinical practice. Surveillance strategies after curative treatment of colorectal cancer. N Engl J Med 2004;350:2375-82.
5. Liu CL, Fan ST, Lo CM, Law WL, Ng IO, Wong J. Hepatic resection for colorectal liver metastases: prospective study. Hong Kong Med J 2002;8:329-33.
6. Cromheecke M, de Jong KP, Hoekstra HJ. Current treatment for colorectal cancer metastatic to the liver. Eur J Surg Oncol 1999;25:451-63.
7. Titu LV, Breen DJ, Nicholson AA, Hartley J, Monson JR. Is routine magnetic resonance imaging justified for the early detection of resectable liver metastases from colorectal cancer? Dis Colon Rectum 2006;49:810-5.
8. Tjandra JJ, Chan MK. Follow-up after curative resection of colorectal cancer: a meta-analysis. Dis Colon Rectum 2007;50:1783-99.
9. Kaplan GL, Meier P. Nonparametric estimation from incomplete observations. J Am Stat Assoc 1958;53:453-81.
10. Secco GB, Fardelli R, Gianquinto D, et al. Efficacy and cost of risk-adapted follow-up in patients after colorectal cancer surgery: a prospective, randomized and controlled trial. Eur J Surg Oncol 2002;28:418-23.
11. Mäkelä JT, Laitinen SO, Kairaluoma MI. Five-year follow-up after radical surgery for colorectal cancer. Results of a prospective randomized trial. Arch Surg 1995;130:1062-7.
12. Pietra N, Sarli L, Costi R, Ouchemi C, Grattarola M, Peracchia A. Role of follow-up in management of local recurrences of colorectal cancer: a prospective, randomized study. Dis Colon Rectum 1998;41:1127-33.
13. Rodríguez-Moranta F, Saló J, Arcusa A, et al. Postoperative surveillance in patients with colorectal cancer who have undergone curative resection: a prospective, multicenter, randomized, controlled trial. J Clin Oncol 2006;24:386-93.

Corrigendum

We have been alerted to errors in the article titled '*Using the National Institutes of Health Stroke Scale (NIHSS) to predict the mortality and outcome of patients with intracerebral haemorrhage*' (October 2008;14:367–70). In the Abstract, the results should have referred to: "The NIHSS can predict 30-day mortality with a sensitivity of 81% and a specificity of 90%. The NIHSS can predict 5-year mortality with a sensitivity of 57% and a specificity of 92%. In predicting favourable functional outcomes at 5 years, the NIHSS had a sensitivity of 98% and a specificity of 16%." In the Discussion (second paragraph) section should have read: "When the NIHSS is used to predict 30-day mortality, it has good sensitivity (81%) and specificity (90%) using a cut-off point of 20 (0-20 vs >20). Using the same cut-off point to predict 5-year mortality, the NIHSS has a lower sensitivity (57%) but good specificity (92%). When using an NIHSS cut-off point of ≤20 to predict a good outcome among survivors at 5 years, its sensitivity was 98% but specificity was 16%. If the cut-off point is changed from 20 to 5 (0-5 vs >5), sensitivity was reduced to 72% but specificity increased to 68%."