hospital, or suffer from postoperative vomiting. Many surgeons find that the most effective way to get round these problems is by placing a jejunostomy tube at the time of operation. Clearly, the placement of surgical jejunostomy is associated with its own limitations and complication rates. We are not aware of any specific data comparing the benefits of different nutritional approaches in these groups of patients.

We find it heartening that the Exeter Group has a nutritional management strategy. Our review suggests that this may not be the case in some units throughout the UK. The key finding of our survey was that dietetic input into the management of patients undergoing oesophagectomy, was not consistent throughout the country. It raised the possibility that dietetic input may be sub-optimal in some centres for patients who are high-risk of malnutrition, both pre-and postoperatively. Clearly, any discussion with an aim to overcome these problems is welcome.

COMMENTS ON

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R Landsmeer, V Tek, V Khanduja. A quick and simple technique for irrigation of open fractures. *Ann R Coll Surg Engl* 2006; **88**: 589–93

COMMENT 1

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Irrigating wounds with a fluid giving set

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We find the described technique of irrigating wounds by inserting a Yankauer sucker into a sterile bag of saline somewhat cumbersome and messy, and therefore employ a simple modification. A sterile blood transfusion giving set is inserted into the port of the fluid bag. The roller valve is rolled upwards to just below the drip chamber, and the tubing cut short at approximately 10 cm. The fluid bag can then be squeezed with one hand whilst retaining control of the rate and direction of flow with the other. Use of a blood transfusion giving set allows a similar maximal flow rate (1.4 l/min), whilst use of a normal fluid giving set is appropriate for smaller wounds with a flow rate of 0.34 l/min.

COMMENT 2

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Problems with the Yankauer sucker for irrigating wounds

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The described technique is innovative and any irrigation system that decreases the contamination and the risk of infection in open fractures should be encouraged.

The Yankauer sucker has an in-built hole in the middle; the authors have not mentioned whether this hole is plugged during wound irrigation. I have used this system and have noted a number of pitfalls. Because of the hole in the Yankauer sucker, optimal wound irrigation would need an assistant. One hand is needed to hold the bag of normal saline and another hand is needed to plug the side hole; the assistant is required to apply some kind of a retractor to direct the irrigating saline in the right direction.

The authors describe that the holes at the far end act as a sprinkler system. I wonder how this sprinkler system helps in removing debris and decreasing contamination. The disadvantage of this sprinkler system is that the irrigating fluid falls well away from the margins of a small size wound. There are four holes at the far end, all being at 90° to one another and are impossible to plug because of their proximity to the outlet. They are ideally meant for suction. This is a low-pressure system by gravity flow and might allow large quantity of fluid to be delivered to the wound but has pitfalls mainly in design. Madden *et al.*¹ showed that the efficacy of irrigation increases directly with the pressure at which a solution is delivered to the wound. Although irrigation, diminishes bacterial count, only high-pressure flow has been shown to bring about significant reduction of bacteria and debris in each type of wound.² This system is suitable for large wounds and can not be used as a high-pressure system as any increase in pressure on the bag would direct the fluid further away through the four side holes at the far end.

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