Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the Notice printed on the inside back cover. Tables and figures should only be included if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and to subedit contributions to ensure clarity.

Response to paper by SP Smith

Olecranon fractures – a reliable technique for accurate positioning of the tension band wire doi 10.1308/147870804939

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We would agree that it is important to position the tension band adjacent to bone for the tension band principle to function. We prefer to use a 14-gauge canula in a similar fashion to that described. A standard suction drain costs £10 whereas a canula costs 74 pence. Whilst this technique is important for the biomechanical principle to work, the problem of prominent metalwork is more often due to the protrusion of the Kirshner wires. This is best prevented by ensuring there are no fibres of triceps tendon between the tension band and the bent wires. We make a 1 cm longitudinal incision down to the tension band until it is visible and punch the turned wires down. We feel this is an important method of reducing the need for subsequent removal of metalwork.

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Response on behalf of the authors

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I thank Mr Shah and Professor Haray for their interest in our paper, and for drawing my attention to their recent

publication on the subject. We have recently re-audited the urgent referral pathway and found that the situation has deteriorated further: two years on from the original study, there has been no improvement in the appropriateness of GP referral via the urgent pathway but these referrals now account for only 9% of all colorectal cancers. It is, of course, self-evident that broadening the referral criteria will increase sensitivity at the expense of specificity: taken to its logical conclusion if all patients with bowel symptoms are seen and investigated urgently, irrespective of age, the pick-up rate will be 100%. Indeed, the logic of this argument is so inescapable that we have bowed to the inevitable. As a result of appointing a second colorectal surgeon and training two colorectal nurse practitioners in flexible sigmoidoscopy we now aim to see all referrals with colorectal symptoms within 2 weeks.

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Hand-held Doppler to assess valvular incompetence – a new OSCE station?

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Each year, half a million patients consult their GP regarding varicose veins.¹ Management decisions are based on the assessment of valvular incompetence, for which medical students are taught a series of clinical tests such as the 'tap test', 'cough test', and 'Trendelenburg test'. However, in practice, vascular surgeons use hand-held Doppler probes (HHD), and duplex scanning as necessary. This inconsistency prompted a review of the literature regarding the accuracy of these clinical tests, bearing in mind the present day emphasis on evidence-based medicine.

An early report by McIrvine *et al.*² is well cited; pre-operative clinical tests for saphenofemoral incompetence were compared with findings at surgery in 105 patients for whom surgery had been recommended. The most accurate test was the tourniquet + HHD (sensitivity, 0.90; specificity, 0.45). More recently, DePalma *et al.*³ looked at the accuracy of clinical tests (cough test, tap test) and HHD for diagnosing saphenofemoral incompetence. Reflux was identified by duplex scanning, and subsequently confirmed operatively. Sensitivity was 48% for both clinical tests and HHD, and the addition of HHD increased specificity and raised PPV to 83%. Similarly, Singh *et al.*⁴ asked surgeons to 'hypothetically' commit to one of a selection of management protocols, based on findings at pre-operative assessment. Inappropriate surgery would have been performed on 14 limbs (20%) and 9 limbs (13%), had clinical examination with a tourniquet, and a tourniquet + HHD been used, respectively.

Kim *et al.*⁵ added further support to the above findings, using duplex scanning as their gold standard. Sensitivities and specificities of clinical tests ranged from 0.18–0.97, and 0.20–0.92, respectively. HHD was far superior (sensitivity, 0.97; specificity, 0.73 at saphenofemoral junction).

Although study design limits the direct comparison of the above results (variation between tests, lack of description of tests,⁴ selection bias²), it is evident that the

evidence base for the use of these clinical tests is lacking. In fact, the studies only lend support for the removal of these tests from the medical curriculum.

Surely it is time to wave good-bye to tradition, and embrace the practice of evidence-based medicine?

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