3. Four of the 5 papers quoted in your letter were published after our paper had been submitted and accepted for publication. These papers are all based on the laboratory setting and a selected group carry out the experiments. They do, however, confirm the superior efficacy of chlorhexidine. Unfortunately, in real life, all individuals are different and they carry out the same pattern of recommended hand washing differently from each other. The aim of this study was to demonstrate that laboratory results in a controlled setting are very difficult to achieve in a realistic work environment – there is no such thing as a control group in the operating theatre.

I am disappointed with your response as I am certain no orthopaedic surgeon will only rely on alcohol to perform major surgery along with insertion of prosthesis. Alcohol should be used to disinfect an already clean hand and not the reverse.

At the end of the day, safety of the patient needs to guide us: as a surgeon, I would not recommend alcohol hand rub alone as a means of disinfection especially for orthopaedic surgeons. It may be sufficient for general surgery, ENT or other specialities where the contamination from body flora is inevitable but not in orthopaedic surgery where a clean operative site and clean hands are vital.

COMMENT ON

doi 10.1308/003588406X106531

SM Sarasin, MJ Walton, HP Singh, DI Clark. Can a urinary tract symptom score predict the development of postoperative urinary retention in patients undergoing lower limb arthroplasty under spinal anaesthesia? A prospective study. *Ann R Coll Surg Engl* 2006; **88**: 394–8

doi 10.1308/003588407X155699

Use of nomogram to predict acute urinary retention

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We agree with the authors, that male patients over 70 years of age undergoing lower limb arthroplasty under spinal anaesthesia are at high risk of developing acute urinary retention (AUR). This is due to a combination of benign prostatic hyperplasia, immobility, spinal anaesthesia and postoperative analgesia.

The use of IPSS/AUA-SI score is a useful means of assessing prostate symptoms and there is evidence to indicate patients

with moderate-to-severe symptoms have a higher risk of developing AUR in the community.¹ However, using this score alone is not a significant predictor of AUR,² so it is not surprising it lacks accuracy in this series. Slawin *et al.*² suggested using a nomogram with a combination of parameters including IPSS/AUA-SI, PSA, prostate size and flow rate – a simple non-invasive test, providing a much more accurate prediction of the likelihood of AUR.

Studies are currently underway to assess the value of the newer generation of α -blockers in preventing postoperative AUR. Indiscriminate catheterisations of all male patients over 70 years old run the risks of urethral trauma and subsequently urethral stricture as well as urinary sepsis. Until the results of these studies are available, it may be useful to use a nomogram to predict outcome and catheterise only the high-risk group.

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AUTHOR'S RESPONSE

doi 10.1308/003588407X155707

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The intention of our study was to ascertain whether or not the simple IPSS/AUA-SI questionnaire would be of use in the prediction of postoperative urinary retention in the pre-operative assessment clinic. We felt there was sufficient evidence in the literature with regard to its usefulness as a predictive tool for AUR to warrant further investigation. We agree that it is not a significant predictor of AUR, but while the use of other parameters in combination with IPSS/AUA-SI as suggested may be more accurate, their use in the busy pre-operative setting would be impractical. It would require referral to urology services for both examination and interpretation of results, which would significantly increase workload, costs and waiting times. This would prove unpopular with patients and management alike.

We await the results of the studies assessing the newer generation of α -blockers with interest.