Figure 1 Nail cleaners

Ecouen, France] and middle [Becton Dickinson, Franklin Lakes, NJ 07417-1884, USA]) and it was not specified which one to use. We tried using the one on the left in the figure and failed to prise the nail from its bed. The pointed end cannot be used and so faces the surgeon's hand putting the surgeon at risk of self-harm if it slips during the procedure. The length of the plastic cleaner does not give an adequate lever arm. This combined with the fact that it is malleable makes the procedure difficult and the sharp tip can cause injury to the surgeon. Lastly, although the plastic cleaners come with a surgical hand-brush impregnated with a solution of chlorhexidine or PVP iodine, they are not sterile. For these reasons we do not recommend the cleaner found in hand-scrubbing packs for prising the nail. We routinely use the McDonald dissector (Fig. 1, top) for the above procedure. A long lever arm and blunt ends make it a very safe and easy to use instrument.

AUTHOR'S RESPONSE

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We use the nail cleaner found in the 'E-Z Scrub' scrubbing packs. We direct the convex surface towards the nail bed. We find avulsing the nail using this instrument to be fast and clean; we have not yet experienced any complications.

COMMENTS ON

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Role of bone scintigraphy

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We agree and compliment the authors on a comprehensive review of the literature. It has been highlighted in many articles that there needs to be a policy change in our management of suspected scaphoid fractures.

As stated in the article, bone scintigraphy and magnetic resonance imaging (MRI) are superior to repeat X-rays. MRI and bone scintigraphy are similar in diagnosing occult injuries and shortening the immobilisation. MRI has the advantage that it diagnoses ligamentous injuries.^{1,2} Bone scanning is relatively inexpensive at around £10 for the isotope. It detects occult carpal fractures other than scaphoid. Activity at fracture may correlate with prognostic features.

There are many difficulties in accessing early MRI compared to bone scintigraphy.

There has been controversy over the immobilisation of scaphoid fractures.^{3,4} This would offer an explanation for the difference in management.

Our protocol is that the suspected scaphoid patient is immobilised in a Colles backslab after negative primary scaphoid X-ray. The patient returns in 10–14 days for review by a senior accident and emergency team member in clinic. If a scaphoid fracture is still suspected, a Colles cast is used and a bone scan is performed within 3 days. Repeat X-rays are not requested. The patient is seen in fracture clinic within a week by the orthopaedic team with the bone scan results. This process has been audited and presented; it is recommended as part of a department protocol for those sites where nuclear medicine is available.⁵

References

1. Thorpe AP, Murray AD, Smith FW, Ferguson J. Clinically suspected scaphoid fracture: a comparison of magnetic resonance imaging and bone scintigraphy.