Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. 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 subedit contributions to ensure clarity.

COMMENTS ON

doi 10.1308/003588405X50967

Callaghan M, Lewis DK, Chipwete J, Borgstein E. HIV seroprevalence in the surgical wards of Queen Elizabeth Central Hospital, Blantyre, Malawi. *Ann R Coll Surg Engl* 2005; **87**: 308

doi 10.1308/003588406X117016

Increase in septic pathology is associated with increase in HIV seroprevalence

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This interesting presentation of HIV seroprevalence in the surgical wards of Queen Elizabeth Central Hospital, Blantyre mentions a belief that surgical sepsis has increased in sub-Saharan Africa but says that there are no studies to support it. My colleagues and I reviewed all operating theatre log books in four hospitals in Malawi over the period 1975–2000 and found that there was a dramatic rise in surgery being done for septic pathology and that this rise mirrored the rise in HIV seroprevalence in the general public.¹ We could not demonstrate a causal link but the facts are strongly suggestive of this.

Reference

1. Lavy C, Schmidt C, Kalua E, Phuka J. The resistible rise of surgical sepsis in Malawi. *Tropical Doctor* 2002; **32**: 98–9.

AUTHOR'S RESPONSE

doi 10.1308/003588406X117025

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I was pleased to read of Chris Lavy's study, which confirms a wide-spread perception among surgeons working in sub-Saharan Africa. It will be interesting to see over the next few years whether antiretroviral therapy, plus improved public awareness of HIV transmission, results in a reduction of HIV prevalence and so a reduction of surgical sepsis. Let us hope it does.

COMMENTS ON

doi 10.1308/003588405X51173

Bhangal KK, McNab I. A technique for nail avulsion using the cleaner found in hand-scrubbing packs. *Ann R Coll Surg Engl* 2005; **87**: 388

COMMENT 1

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Alternate nail cleaners

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We read this Technical Tip with interest and tried it out but would like to express concerns regarding the use of plastic nail cleaners. Different types of nail cleaners are available (Fig. 1, left [Laboratories Pharmaceutiques Vygon, 5A 11 Reuadeline, 95440

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

doi 10.1308/003588405X51074

Tai CC, Ramachandran M, McDermott ID, Ridgeway S, Mirza Z.

Management of suspected scaphoid fractures in accident and emergency departments – time for new guidelines. *Ann R Coll Surg Engl* 2005; **87**: 353–7

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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.