patient's wound appears to be desloughed and cleaner revealing granulation tissue, yet is no smaller nor more epithelialised. The selection of negative pressure wound therapy (NPWT) for this case is flawed: it is recommended for post surgical abdominal wounds following debridement but not in the presence of necrotic wound eschar.¹ Furthermore the NPWT trial should be ceased if no improvement occurs after two dressing changes.¹ Although all conventional dressings in this case were unsuccessful, LarvE® are prescribable for wound debridement and their value as biosurgeons has been recognised since the napoleonic wars.² Rapid bedside debridement with Versajet® could also have been an appropriate adjunct to prepare this wound for NPWT and later skin grafting.³

The search for 'wound solutions' will continue, but the ancient principles of removal of non-viable tissue, maintaining a moist uninfected wound on a metabolically adequate patient will result in the maximal speed of wound healing.

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AUTHORS' RESPONSE

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We agree that traditional wound debridement and simple dressing is sufficient for the majority of surgical wounds. Our experience with NPWT is that, although it can speed wound healing, the time period is often prolonged, patients can find it uncomfortable, and it is both costly, and requires specialist nursing input. A recently published systematic review of NPWT concluded that this modality did not offer earlier wound healing in chronic and diabetic wounds,¹ and we concur that further research into novel wound solutions, such as topical insulin, is required. Insulin application may also act synergistically with alternative strategies, such as larval debridement and honey dressings, and further clinical trials would be beneficial.

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LETTER

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Compensation claims and carpal tunnel decompression

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Carpal tunnel syndrome is the most common upper limb diagnosis presenting to hand clinics,¹ but the number of patients making a compensation claim related to carpal tunnel decompression in the UK remains unknown.

A total of 204 anonymous, self-reported, socio-economic questionnaires were completed in 2004 by patients having undergone carpal tunnel decompression in 2000.

Of the employed patients, 7% (12/175) were involved in a compensation claim relating to carpal tunnel syndrome. This is in stark contrast to a recent similar study from the US where 38% of patients had received workers compensation.² Patients who self-reported no symptom improvement following carpal tunnel decompression were almost 5 times more likely to make a claim than patients who self-reported that their symptoms had improved (Odds ratio 4.8 [1.3–17.6]; Table 1).

Manual workers required a median of 6 weeks (IQR, 4–8 weeks) sick leave following surgery compared with 4 weeks (2–6 weeks) for non-manual workers ($n = 120$ and $n = 55$ respectively; $P = 0.001$), useful information to utilise during carpal tunnel decompression consent.

Table 1 Effect of outcome following carpal tunnel decompression on compensation claims ($P = 0.004$)

	Compensation claim		
	Yes	No	Total
Symptom improvement	8	150	158
No symptom improvement	4	13	17
Total	12	163	175