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.

References

- Teot L. VAC (vacuum assisted closure) for the treatment of difficult wounds. Available at <http://www.etr.org/bulletin7_4/abstracts/page6.html>.
- Rivinus EF. Observations on wounds and their complications by erysipelas gangrene and tetanus. *Clin Chir Transl (Paris)* 1932; **51/52**: 34
- Granick MS, Posnett J, Jacoby M, Moruthun S, Ganchi PA, Datiashvili RO. Efficacy and cost-effectiveness of a high-powered parallel waterjet for wound debridement. *Wound Repair Regen* 2006; **14**: 394–7.

AUTHORS' RESPONSE

doi 10.1308/003588408X321846

JM WILSON, R BAINES, ED BABU, CJ KELLEY
Department of General Surgery, Hillingdon Hospital, Middlesex, UK

CORRESPONDENCE TO

JM Wilson, Department of General Surgery, Hillingdon Hospital, Pield Heath Road, Middlesex UB8 3NN, UK
E: medjmw@yahoo.co.uk

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.

Reference

- Ubbink DT, Westerbos SJ, Nelson EA, Vermeulen H. A systematic review of topical negative pressure therapy for acute and chronic wounds. *Br J Surg* 2008; **95**: 671–3.

LETTER

doi 10.1308/003588408X321846

Compensation claims and carpal tunnel decompression

PHILIP A STOREY, SOHAIL AKHTAR, MARY J BRADLEY, NEVILLE RM KAY, TOMMY LINDAU, FRANK D BURKE
Pulvertaft Hand Centre, Derbyshire Royal Infirmary, Derby, UK

CORRESPONDENCE TO

Philip A Storey, Pulvertaft Hand Centre, Derbyshire Royal Infirmary, London Road, Derby DE1 2QY, UK
E: phil.storey@nhs.net

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

Further research is of paramount importance if trends in work-related compensation claims in the UK follow those reported from the US.

References

1. Hayward AC, Bradley MJ, Burke FD. Primary care referral protocol for carpal tunnel syndrome. *Postgrad Med J* 2002; **78**: 149–52.
2. Ellis RA, Novak CB, Mackinnon SE, Cheng CJ. Workers' compensation, return to work, and patient satisfaction after carpal tunnel decompression. *Am J Orthop* 2007; **36**: E63–6.

COMMENT ON

doi 10.1308/003588408X285720

PJ Tomlinson, WJ Harries. The use of a surgical glove in the prevention of tourniquet-associated chemical burns. *Ann R Coll Surg Engl* 2008; **90**: 255

doi 10.1308/003588408X321846

Prevention of chemical burns

D BAYNE

Department of Plastic Surgery, The Mountbatten Plastic Surgery Unit, Royal Hospital Haslar, Gosport, Hampshire, UK

CORRESPONDENCE TO

D Bayne, Department of Plastic Surgery, The Mountbatten Plastic Surgery Unit, Royal Hospital Haslar, Gosport, Hampshire PO12 2AA, UK. E: paperscorrespondence@inbox.com

The authors' tip to prevent chemical burns fails to emphasise that alcoholic skin preparation is the greatest risk factor, yet is exchangeable for the much safer aqueous povidone-iodine.¹ The chemical burn below the unprotected tourniquet is well documented and is still encountered in our practice as plastic surgeons.²

The Atlantech tourniquet drape (Arthrocare) costs about £3.50 and can protect large thighs and upper limbs providing an adhesive seal to the skin, integrated padding and fold-over protection of the tourniquet from soiling. A pair of surgical gloves costs about £1.15 with a less effective elastic, there is also the possible disadvantage of a venous tourniquet effect when the pneumatic tourniquet is deflated.

We suggest that Bruner's *Ten Rules for Safe Tourniquet Use* should be updated to include:^{3,4} (i) using an occluding dressing or drape to prevent fluid spread into the padding or onto the tourniquet; and (ii) a new eleventh rule to avoid alcoholic skin preparations for paediatric and elderly patients and its restricted use on adults.

The patient morbidity and cost to the NHS from adverse tourniquet events will be greatly reduced with adherence to these rules.

References

1. Edwards PS, Lipp A, Holmes A. Preoperative skin antiseptics for preventing surgical wound infections after clean surgery. *Cochrane Database Syst Rev* 2004; **3**: CD003949.
2. Dickinson JC, Bailey BN. Chemical burns beneath tourniquets *BMJ* 1988; **294**: 1513.
3. Bruner JM. Safety factors in the use of the pneumatic tourniquet for haemostasis in surgery of the hand. *J Bone Joint Surg Am* 1951; **33**: 221–4.
4. Braithwaite I, Klenerman L. Burns under tourniquets – Bruner's ten rules revisited. *J Med Def Unions* 1996; **12**: 14–5.

AUTHORS' RESPONSE

doi 10.1308/003588408X358738

PJ TOMLINSON, WJ HARRIES

Department of Orthopaedic Surgery, Frenchay Hospital, Bristol, UK

CORRESPONDENCE TO

PJ Tomlinson E: petetomlinson1@hotmail.com

Although it is well recognised that tourniquet-associated chemical burns occur more commonly with alcohol, rather than aqueous-based preparations, this complication is not exclusive to such solutions. Nahlieli *et al.*¹ described three cases of burns occurring in association with povidone-iodine skin preparation fluids as analogous to an acute accelerated decubitus ulcer, arising as a result of a combination of irritation, maceration, friction and pressure.

Commercially available tourniquet covers such as the Atlantech drape (Arthrocare) are often superior to non-commercial alternatives, having been specifically designed for the purpose. However, in the climate of a publicly funded health-care system, such commercial covers are not always obtainable. The purpose of our article was to highlight a viable alternative that is cheap and readily accessible in theatre. The surgical glove shown in the article (see Fig. 2) is a non-sterile latex glove. These retail at £23.40 (excluding VAT) for 1000 gloves. This equates to £0.02 per use as opposed to £1.15 as suggested.

With respect to Bruner's rules regarding safe tourniquet use,^{2–4} we accept that the avoidance of alcohol-based skin preparations should be included. However, using some form of barrier to occlude a tourniquet in order to prevent the soaking of wool already forms one of the ten rules.

References

1. Nahlieli O, Baruchin AM, Levi D, Shapira Y, Yoffe B. Povidone-iodine related burns. *Burns* 2001; **27**: 185–8.
2. Kutty S, McElwain JP. Padding under tourniquets in tourniquet controlled surgery: Bruner's ten rules revisited. *Injury* 2003; **33**: 75.
3. Bruner JM. Safety factors in the use of the pneumatic tourniquet for haemostasis in surgery of the hand. *J Bone Joint Surg Am* 1951; **33**: 221–4.
4. Braithwaite I, Klenerman L. Burns under tourniquets – Bruner's ten rules revisited. *J Med Def Unions* 1996; **12**: 14–5.