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.

LETTER

doi 10.1308/003588409X464513

An interesting and unusual case of incontinence

JM PERRY, JT ALLARDICE

Department of General Surgery, Jersey General Hospital, St Helier, Jersey, UK

CORRESPONDENCE TO

JT Allardice, Department of General Surgery, Jersey General Hospital, St Helier, Jersey JE1 3QS, UK
E: j.allardice@health.gov.je

We should like to bring to your attention an interesting and unusual case of postoperative incontinence. Two days after laparotomy, while confused, a normally continent 86-year-old man traumatically pulled out his urinary catheter. The catheter was discarded at the time by the night nursing staff. Following this, the patient was completely and persistently incontinent to urine.

Two pelvic ultrasound scans showed a low residual volume, and spinal magnetic resonance imaging was normal. A flexible cystoscopy was performed identifying the cause – the distal 14 cm of the catheter bridging the bulbar urethra, acting as a stent. This was removed at cystoscopy resulting in a return to normal continence.

Due to the low friction nature of the silicone catheter, it was surprising that the catheter section remained *in situ* over the bulbar urethra. Has anyone else seen a similar case as none of the surgical team involved had come across this scenario before?

COMMENT ON

doi 10.1308/003588409X358971

S Sinha, A De, N Jones, M Jones, RJ Williams, E Vaughan-Williams. Patients' attitude towards the use of a chaperone in breast examination. *Ann R Coll Surg Engl* 2009; **91**: 46–9

doi 10.1308/003588409X464667

Doctors' attitude towards the use of chaperones for intimate examinations

A KHOO, O WISEMAN

Lister Hospital, Stevenage, UK

CORRESPONDENCE TO

Anna Khoo, E: kooi_ai@hotmail.com

We read this article with interest having conducted a similar study amongst 290 urology out-patients undergoing digital rectal and vaginal examinations. Our findings were comparable, concluding that patients should be offered a chaperone even if then declined.

We also surveyed 47 doctors to discover doctors' attitude towards chaperones. Sinha *et al.* do not emphasise that the chaperone is for the protection of both patient and clinician. Thirty-two percent of patients in the study of Sinha *et al.* and 22% of patients in our study preferred the chaperone to be their spouse or relative whilst 60% of the doctors we surveyed preferred the chaperone not to be related to the patient. Guidance from the General Medical Council (GMC) suggests that 'a relative or friend of the patient may be an acceptable chaperone' contrary to the recommendations of the Ayling Inquiry that chaperones should not be friends or relatives of the patient.^{1,2}

Significantly for medicolegal implications, we found that 74% of doctors did not document chaperone use. GMC guidance recommends that doctors 'should record any discussion about chaperones and its outcome', advice reiterated by the Medical Defence Union.^{1,3}

We would like to emphasise that chaperones are for the protection of doctors as well as patients, and their use and documentation of it should be an integral part of the examination routine.

References

1. General Medical Council. Intimate Examinations. Chaperones. In: *Maintaining*

Boundaries. London: GMC, 2006 <http://www.gmc-uk.org/guidance/current/library/maintaining_boundaries.asp#10>.

2. Department of Health. Publications, Policy and Guidance. In: *Committee of Inquiry independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling Section 2.58* <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4088996>.
3. Medical Defence Union. *GP registrars advised always to offer a chaperone for intimate examination*. Media release, 10 February 2006 <http://www.themdu.com/section_medical_students/topnav_support_and_education_1/nav_case_histories>.

COMMENT ON

doi 10.1308/003588409X359213

WJC Thomas, JRD Murray. The incidence and reporting of needlestick injury amongst UK surgeons. *Ann R Coll Surg Engl* 2009; **91**: 12–7

doi 10.1308/003588409X464676

Needlestick injury management – what's the solution?

PA McCANN

Department of Trauma and Orthopaedic Surgery, Gloucester Royal Hospital, Gloucester, UK

CORRESPONDENCE TO

PA McCann, 80 Raleigh Road, Southville, Bristol BS3 1QT, UK
E: pasmccann@hotmail.com

The management of needlestick injury is a troublesome problem for surgeons for a variety of reasons. As Thomas and Murray highlight, it is a combined failure of systems reporting and surgical attitudes that place surgeons at risk.

It has previously been shown that surgeons possess little insight into the risks of needlestick injury.¹ In a survey of 45 consultants and trainees, we found that the estimated transmission rates for HIV, hepatitis B and hepatitis C were inaccurately perceived to be 40%, 16% and 24%, respectively. *Ad hoc* risk assessment was performed by 42% of respondents as opposed to following local reporting protocols. To examine why concordance was so low, a second survey was completed examining the reasons influencing such decisions.² The chief reasons cited were disruption to the operating list and a perception that the risk of transmission was insignificant. This reluctance was reflected again in the low numbers of surgeons following local reporting protocols (19%). Despite this, we found that 35% of participants had at least one injury that caused significant anxiety.

Orthopaedic surgeons may be more prone to needlestick injury due to the prevalence of bone spikes in the operative field and the use of sharp orthopaedic instruments such as drills, saws and wires. There is also increased risk of contamination due to aerosolisation of body fluids secondary to

air-driven power tool use. The advent of needlestick or sharps injury is always unpleasant and, on occasion, deeply worrying. Given that blood-borne viral diseases are becoming increasingly prevalent,^{3,4} all patients should be regarded as high-risk, regardless of known viral status.

Thomas and Murray rightfully concluded that occupational health processes need to be streamlined so as avoid deterrence of incident reporting. We must also strive to remove the culture of self risk assessment to promote safer working practices within the environment.

With constant time pressure on operating lists, consultants and trainees will be reluctant to forfeit time going through rigorous machinations of needlestick injury reporting. Perhaps a national protocol is needed to ensure familiarity and compliance with the necessary steps.

References

1. Kennedy R, McCann PA, Southgate C. Surgeons and the risk of blood borne viral infections; a study of attitudes and practice. *Br J Surg* 2007; **94** (Suppl 3): 1–31.
2. Kennedy R, Kelly S, Gonsalves S, McCann PA. *Barriers to the Reporting and Management of Needlestick injuries among Surgeons*. The Royal College of Surgeons of Edinburgh, Audit Symposium, March 2007.
3. Health Protection Agency. *Eye of the Needle, United Kingdom Surveillance of Significant Occupational Exposures to Bloodborne Viruses in Healthcare Workers*. 2006
<<http://www.hpa.org.uk/publications/PublicationDisplay.asp?PublicationID=54>>.
4. Department of Health. *Guidance for Clinical Healthcare Workers: Protection against infection with blood borne viruses*. 1998
<http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=SS_GET_PAGE&ssDocName=DH_4003818>.

AUTHORS' RESPONSE

doi 10.1308/003588409X464685

WILLIAM THOMAS

Department of Trauma and Orthopaedics, Royal United Hospital, Bath, UK

CORRESPONDENCE TO

William Thomas, Isther Cottage, Hampton Row, Bath BA2 6QS, UK
E: williamthomas@doctors.org.uk

I thank Mr McCann for his comments and congratulate him on his work in this important area. The *ad hoc* risk assessment one makes following a contamination event is risky. I concur with Mr McCann's findings^{1,2} that disruption to operating lists and an inaccurate perception of risk of transmission of a blood-borne virus (BBV) are key factors influencing the post event action. I would also add that an assessment made rapidly and with little consideration, on the basis of an 'educated' guess regarding the BBV status of the patient compounds the unsafe nature of this decision.

The transmission of a BBV to an operating surgeon in this country would be a tragedy. To reduce the risk of this