Boxer's fracture

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COMMENT ON

Jones R, Burdett S, Jefferies M, Guha AR. Treating the boxer's fracture in Wales: a postal survey. *Ann R Coll Surg Engl* 2010; **92**: 236–9

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Jones and colleagues mention that there is no evidence to indicate plaster immobilisation as a superior treatment and list as its disadvantages: joint stiffness, decreased functionality and the need for follow-up which could be an inconvenience for the patient and an unnecessary use of clinical resources. To this I would add the inability to undertake any job where good hand hygiene is essential. For a patient in a healthcare role this treatment represents an iatrogenic incapacity for work.

Barrel and cuff technique for a bloodless field

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COMMENT ON

Mitchell T, Hignett S, Chandrasekar R. The barrel and cuff technique for a bloodless field. *Ann R Coll Surg Engl* 2009; **91**: 625

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As a surgeon involved heavily in dialysis access creation and revisional surgery, I would like to congratulate the authors in describing this technique. At the same time, I would like to point to the following:

1. Using a tourniquet that will compress the out-flow vein but not the in-flow artery could make the risk of bleeding higher. Therefore, we avoid tourniquets in arterio-venous fistulae.
2. We adhere to the principles of proximal and distal control

of the artery and control of the vein prior to dissecting out the area of revision. Unexpected bleeding can always be controlled by local pressure.

3. I am yet to encounter a brachial artery that is incompressible – we have seen many radial arteries that are heavily calcified.
4. I am concerned that a syringe that is poorly placed under the tourniquet could lead to cracking of the plaques in the brachial artery as well as cause compression of the adjacent median nerve.

I would be interested to know the number of patients treated in this way and their percentage out of the number of cases of revisional fistula surgery.

Training orthopaedic specialist trainees

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COMMENT ON

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We read with interest the results of Eardley *et al.* regarding trainee perceptions of damage control orthopaedics (DCO) and early total care (ETC) trauma management.

They subdivide perceived exposure, decision making, operative role and adequacy of training with regards to DCO, ETC and management of the floating knee with vascular compromise. The authors state that overall perceptions in confidence and adequacy of training are generally positive. We wonder if this sentiment is misplaced.

The example of a floating knee with vascular compromise is a potentially limb-threatening injury, which, as noted, is rare. Only 29.7% of trainees (the largest subdivision) consider themselves fully confident in their decision making and stabilisation in this scenario. This is interesting considering that 31.5% have never seen a case and a further 37.5% have witnessed one only every 2 years. The perceived operative role of trainees for this injury is 32.8% to be performing the procedure. As noted by the authors, this perceived operative role is not supported by actual logbook data.