Boxer's fracture

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doi 10.1308/003588410X12699663904033

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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

doi 10.1308/003588410X12628812458176

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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doi 10.1308/003588410X12699663904079

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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

doi 10.1308/003588409X464630

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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doi 10.1308/003588410X12699663904114

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COMMENT ON

Eardley WGP, Taylor DM, Parker PJ. Training in the practical application of damage control and early total care operative philosophy – perceptions of UK orthopaedic specialist trainees. *Ann R Coll Surg Engl* 2010; **92**: 154–8

doi 10.1308/003588410X12518836440045

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.

To optimise outcome, major trauma needs senior-led care to direct decision making, surgical action and also facilitate teaching of trainees.^{1,2} Similarly, surgical exposure and experience is demonstrated to improve outcome, decrease complication rate and length of stay.³⁻⁵

These data imply an over-confident cohort of trainees, perceiving themselves proficient at managing trauma they may have not previously witnessed.

It would have been useful to see the data stratified into trainee years to assess confidence as training progresses. More importantly, it would be valuable to assess corroboration between perceived confidence and actual surgical proficiency.

We question the relevance of measuring confidence when actual ability to manage such cases is far more important and relevant.

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AUTHORS' RESPONSE

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doi 10.1308/003588410X12699663904150

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We appreciate Avis and Mutimer's interest in our survey of 232 orthopaedic trainees' perceived confidence in the management of and exposure to significant trauma.

Apparent from the title, this study of a quarter of UK orthopaedic trainees reflects how often they perceive to be involved in index cases. It represents how trainees perceive their confidence and adequacy of training in the management of significant injury and details their perceived operative role.

Concern of misplaced sentiment regarding adequacy of training is more representative perhaps of a misplaced interpretation of the results. In addition, to illustrate their points, they cite surgical experience and economic outcomes from elective shoulder arthroplasty and thyroidectomy, evidence that is somewhat distant from trauma care. Their other reading matter is over 20 years old.

Analysis of training in operative orthopaedics has been made possible recently through peer-reviewed publication of data from the national operative logbook. A significant resource and source of valuable benchmarking data, the logbook is, however, limited to operative interventions. Trainee confidence and exposure to the overall management of significant trauma is not currently an aspect of the logbook and our study is the first to attempt to gauge these important aspects of training.

As such, this is the first demonstration of how trainees perceive their exposure to significant trauma, their confidence in its management and the adequacy of their training – issues that cannot be assessed through graded participation in an operative procedure alone.

If trainees demonstrate a perceived adequacy of training and a level of confidence greater than that expected of their seniority, then this must be factored in to the overall assessment of training as a whole and not dismissed out of hand. We do not vouch for the competency of surgeons completing the survey, merely report their responses.

In terms of demonstrating responses across training years, as stated in the paper, this was submitted although entirely appropriate editorial constraints prevented its inclusion within the published article. Should Avis and Mutimer wish, this information can be made available to them.

Training is in a state of flux. Whilst objective measures of participation in operations are of value, we ignore subjective assessments of trainee confidence, exposure and ability to manage cases at our peril. As stated, their inclusion alongside existing logbook data will enhance the assessment of training.