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/submissions/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.

RJ Egan, JDT Morgan, SA Norton

Department of General and Bariatric Surgery, Southmead Hospital, Westbury-on-Trym, Bristol, UK

doi 10.1308/003588410X12771863936008

CORRESPONDENCE TO

Richard Egan, E: richard.egan@nbt.nhs.uk

COMMENT ON

Howarth D, Inman D, Lingard E, McCaskie A, Gerrand C. Barriers to weight loss in obese patients with knee osteoarthritis. *Ann R Coll Surg Engl* 2010; **92**: 338–40

doi 10.1308/003588410X12628812458653

We read with interest this paper on barriers to weight loss in obese patients with knee osteoarthritis. It is increasingly recognised that significant weight loss can be achieved in such patients through bariatric surgery, such as laparoscopic gastric banding or gastric bypass.¹ Using patient-driven weight loss as an incentive for proceeding to arthroplasty will fail to achieve meaningful results.

With a mean body mass index of 34 kg/m² in the study cohort and a documented obesity-related co-morbidity, almost half of the patients may be suitable for referral to a bariatric team, according to National Institute for Health and Clinical Excellence guidelines.² This allows patients to be fully educated with regards to weight loss, whilst receiving the specialist dietary and medical input required. Any operative intervention offered can provide excellent results in terms of weight loss and improvements in associated co-morbidities, including osteoarthritis.^{1,3}

Such procedures will not only reduce the risks of subsequent orthopaedic surgery for these patients but, in some cases, postpone or exclude the need for such treatment.⁴ Excellent results have already been reported for arthroplasty following bariatric surgery.⁵ Although not suitable for all, we would recommend consideration of bariatric surgery in morbidly obese patients presenting with osteoarthritis and

other weight-related musculoskeletal pathology.

References

1. Sjöström L, Lindroos AK, Peltonen M, Torgerson J, Bouchard C, Carlsson B *et al.* Lifestyle, diabetes, and cardiovascular risk factors 10 years after bariatric surgery. *N Engl J Med* 2004; **351**: 2683–93.
2. National Institute for Health and Clinical Excellence (NICE). *Obesity; guidance on the prevention, identification, assessment and management of overweight and obesity in adults*. Guideline CG43. London: NICE, 2006.
3. Adu-Abeid S, Wishnitzer N, Szold A, Liebergall M, Manor O. The influence of surgically-induced weight loss on the knee joint. *Obes Surg* 2005; **15**: 1437–42.
4. Peltonen M, Lindroos AK, Torgerson JS. Musculoskeletal pain in the obese: a comparison with a general population and long-term changes after conventional and surgical obesity treatment. *Pain* 2003; **104**: 549–57.
5. Parvizi J, Trousdale RT, Sarr MG. Total joint arthroplasty in patients surgically treated for morbid obesity. *J Arthroplasty* 2000; **15**: 1003–8.

Pancreatic cancer in the media: the Swayze shift

James ML Williamson, David B Hocken

Department of General Surgery, The Great Western Hospital, Swindon, UK
doi 10.1308/003588410X12771863936044

CORRESPONDENCE TO

James Williamson, E: jmlw@doctors.org.uk

We wonder how much reportage of pancreatic cancer exists in the media and what influences this coverage. We believe that the pancreas itself is not fully appreciated by the general population and most knowledge about it comes from patient information, once the organ has become diseased. Pancreatic cancer thankfully affects a small proportion of the population (either directly or indirectly), but has a poor 5-year survival outcome. This lack of insight into the pancreas, coupled with a relatively low incidence of malignancy means that pancreatic cancer does not have as high profile as other tumours (for example, breast, cervical and lung).

One potential factor for the raised awareness of certain malignancies may relate to celebrities; for example, Kylie Minogue and breast cancer and Jade Goody and cervical cancer. The diseases of both of these celebrities were played out in the media and there were associated increases in screening

of disease in the general population.¹ The very mention of these cancers in the media may have improved public education and awareness. It is possible that the media is one of the most important health information sources available to the general population and, therefore, we are keen to explore how health professionals can influence this resource.²

Patrick Swayze was a popular actor who has recently fought a public battle with pancreatic cancer. We decided to assess the number of articles that existed around the time of his illness to see if he had an influence in the reportage of the disease. The ten most read daily UK newspapers were assessed for the number of articles mentioning pancreatic cancer over a 24-month period, via their online search facilities.³ This period overlapped the dates of Patrick Swayze's illness (January 2008 to September 2009).

A total of 550 articles were reported over this 24-month period, averaging 23 per month. During this period, there were three key events related to Patrick Swayze: March 2008 (diagnosis made public), 38 articles; January 2009 (he developed pneumonia), 78 articles; and September 2009 (he died), 64 articles. The total number of articles relating to him and pancreatic cancer was 180 (*i.e.* one-third of total reportage). Reportage of pancreatic cancer by some newspapers is heavily dependent on this celebrity (95% or more of the articles in three tabloid newspapers related directly to Patrick Swayze).

We believe that health professionals could work in conjunction with public health officials and journalists to form a partnership to ensure a co-ordinated approach in how medical information is presented to the print media. This collaboration would ensure better dissemination of patient education to the population and hopefully enhance the background knowledge of medical conditions.⁴ This new strategy would exist in conjunction with the presentation of medical information by traditional means (consultations and patient information leaflets) and utilise a newspaper's own writing style and format to ensure optimal uptake by readership.⁵

References

1. Chapman S, McLeod K, Wakefield M, Holding S. Impact of news of celebrity illness on breast cancer screening: Kylie Minogue's breast cancer diagnosis. *Med J Aust* 2005; **183**: 247–50.
2. Schwitzer G, Mudur G, Henry D, Wilson A, Goozner M, Simbra M *et al.* What are the roles and responsibilities of the media in disseminating health information? *PLoS Med* 2005; **2**: 576–82.
3. National Readership Survey. *NRS readership estimates – Newspapers and supplements. October 2008–September 2009.* <<http://www.nrs.co.uk/toplinereadership.html>> [accessed November 2009].
4. Williamson JML, Hocken DB. How much vascular disease is reported by the UK media? *Int J Clin Pract* 2010; In press.
5. Williamson JML, Martin AG. Analysis of patient information leaflets provided by a district general hospital by the Flesch and Flesch–Kincaid method. *Int J Clin Pract* 2010; In press.

Operative tourniquets

Frank D Burke, Carlos Heras-Palou

Pulvertaft Hand Centre, Royal Derby Hospital, Derby, UK
doi 10.1308/003588410X12771863936080

CORRESPONDENCE TO

Frank D Burke, E: frank.burke@virgin.net

COMMENT ON

Sandri A, Braithwaite IJ, Abdul-Jabar HB, Sarraf KM. Understanding of intra-operative tourniquets amongst orthopaedic surgeons and theatre staff – a questionnaire study. *Ann R Coll Surg Engl* 2010; **92**: 243–5

doi 10.1308/003588410X1251883644060

We were interested in this paper concerning operative tourniquets. We were particularly interested in their third reference Recommended Practice by the AORM Committee. This paper deals with use of pneumatic tourniquets in the operating theatre in the most comprehensive manner and cites an astonishing 75 references. The advice, in general, was sound and represents good practice. However, we were surprised to see the statement: 'There is general agreement that inflation time should not exceed 60 min for an upper extremity and 90 min for a lower extremity'. Only one paper is cited to support this 'general agreement' – JA McEwen, Tourniquet Use and Care. Regrettably, the AORM document does not cite McEwen correctly. McEwen advises the surgeon should be informed when 60 min has elapsed but goes on to state there is a general agreement that, for reasonably healthy adults, 90 min should not be exceeded.

The Pulvertaft Hand Centre makes very extensive use of upper arm pneumatic tourniquets for elective and traumatic hand surgery, carrying out over 4000 operative procedures per year. We would not accept a 60-min restriction or a 90-min restriction on tourniquet time; our department guidelines recommend to keep the tourniquet up to 120 min, if required.

In spite of this, the senior author can only recall one problem related to prolonged tourniquet use in the last 30 years and that related to an inflation time that was likely to have been well in excess of 2 h. The case involved a partial median and ulnar nerve palsy with almost complete resolution of symptoms over 3 years.

The AORM document would represent probably the most comprehensive publication on the subject and, by and large, is to be recommended, but we think it would be very unfortunate if a maximum inflation time of 60 min was considered to be the upper limit of accepted practice. McEwen is misquoted and 90 min does not represent a ceiling in many hand surgeons' practice. It is easy to see potential medicolegal issues developing if these misconceptions are not addressed.