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

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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.

We would like to thank Sadri and colleagues for a very interesting paper that draws attention to a very important part of our practice. Nevertheless, there does appear to be a potential vulnerability with the source document they were working from and we would welcome wider views from college members concerning the safe upper limit for tourniquet times in the upper and lower limbs.

Testing the distal tibiofibular syndesmosis – Comment 1

Oliver Templeton-Ward

Kingston Hospital NHS Trust, Kingston, Surrey, UK
doi 10.1308/003588410X12771863936242

CORRESPONDENCE TO

Oliver Templeton-Ward, ojtww@doctors.org.uk

COMMENT ON

Rajagopalan S, Upadhyay V, Taylor HP, Sangar A. New intra-operative technique for testing the distal tibiofibular syndesmosis. *Ann R Coll Surg Engl* 2010; **92**: 258
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I read with interest the technical note on testing the distal tibiofibular syndesmosis and thought it a clever technique. I have used it on occasions since and found it simple and effective. I would, however, like to point out to anyone else trying this technique that, in the two figures included in the publication, the medial malleolus fracture had not been fixed prior to testing the syndesmosis, which is obviously necessary. It is not possible to put widening of the clear space down to syndesmotic injury in the absence of intact medial structures.

Comment 2

SDS Newman, DPS Baghla

Department of Orthopaedic Surgery, Ealing Hospital, London, UK
doi 10.1308/003588410X12771863936288

CORRESPONDENCE TO

SDS Newman, E: sdsn198@doctors.org.uk

The authors describe an alternative method for assessment of the integrity of the distal tibiofibular syndesmosis. In their description of the technique, they highlight the importance of fixation of the fibular fracture prior to performing the test. However, they neglect to mention the importance of fixation of any associated medial malleolar fracture prior to testing syndesmotic stability. Indeed, the images accompanying the note show their test being performed on a bimalleolar fracture with the medial malleolar fracture untouched, but the final image shows medial malleolar fracture fixation and syndesmosis screws present. This is in contrast to conventional teaching. In

the majority of bimalleolar fractures, rigid fixation of both medial malleolar and fibular fractures should stabilise the syndesmosis and abolish the need for a syndesmosis screw.^{1,2} The exception to this is if there is co-existing ligamentous disruption medially or laterally, in which case syndesmotic widening would be observed on testing the syndesmosis after fixation of both medial malleolar and fibular fractures.

References

1. Boden SD, Labropoulos PD, McCowin P, Lestini WP, Hurwitz SR. Mechanical considerations for the syndesmosis screw. *J Bone Joint Surg Am* 1989; **71**: 1548–55.
2. Yamaguchi K, Martin CH, Boden SD, Labropoulos PA. Operative treatment of syndesmotic disruptions without use of a syndesmotic screw: a prospective clinical study. *Foot Ankle Int* 1994; **15**: 407–14.

The ‘defensibility’ of surgical injuries

Robert Wheeler

Wessex Regional Centre for Paediatric Surgery, Southampton General Hospital, Southampton, UK
doi 10.1308/003588410X12771863936125

CORRESPONDENCE TO

Robert Wheeler, E: robert.wheeler@suht.swest.nhs.uk

COMMENT ON

Skidmore FD. Guest editorial. *Ann R Coll Surg Engl* 2010; **92**: 271
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Scurr JRH, Brigstocke JR, Shields DA, Scurr JH. Medicolegal claims following laparoscopic cholecystectomy in the UK and Ireland. *Ann R Coll Surg Engl* 2010; **92**: 286–291
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I note the Editorial and linked paper on the ‘defensibility’ of surgical injuries. The fact that 94% of vascular and biliary injury cases are settled out of court supports the contention that such injuries are difficult to defend. Presumably, the defendant solicitors were sufficiently impressed with the expert evidence adduced to make them disinclined to continue their defence. But could this merely reflect the resoluteness of expert advice, if all 61 ‘winning’ opinions came from the same expert, creating a self-fulfilling prophecy? We should know whether this was the case, before reaching a firm conclusion.

Skidmore’s concluding assertion that ‘laparoscopic procedures...when they go wrong are...indefensible’ requires more careful qualification. Scurr’s paper considers 83 non-vascular and non-biliary cases of which 56 (67%) were abandoned, and only 18 settled. These were therefore eminently defensible.

He also suggests that non-essential cosmetic surgery that causes harm is indefensible. This is quite wrong. Success in negligence requires proof of substandard care, together with a causative link between this and any harm that results. Neither the ‘essential’ character nor the ‘cosmetic’ nature of a procedure