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

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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

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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.

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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

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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