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.

Testing the distal tibiofibular syndesmosis – comment 3

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The intra-operative diagnosis of syndesmotom ligament rupture is problematic. Neither plain radiography¹ or clinical testing is completely reliable.^{2,3}

As the authors point out, fibular translation in the coronal plane correlates poorly with diastasis when using the hook test. Candal-Couto *et al.*⁴ demonstrated that translation in the sagittal plane was more significant than movement in the coronal plane after sequential division of the three syndesmotom ligaments in the cadaveric model (8.8 mm vs 1.5 mm). This suggests that intra-operative anteroposterior stressing rather than mediolateral stressing with the hook is a more sensitive test of syndesmotom failure. Why then do the authors advocate testing their technique in the coronal plane?

A further point of note is that this technique of pushing the tibia medially away from the fibula along the 3.5-mm tap will rely upon the patient having sufficient bone quality. In the osteoporotic patient, the tap may subside into the lateral cortex of the tibia and/or lose grip in the fibula, thus preventing analysis of the syndesmosis.

If one wished to stress the syndesmosis in the sagittal plane with this technique, movement would be limited (and the surgeon falsely re-assured) by contact with the tip of the 3.5-mm tap against posterior aspect of the anterior tibial tubercle. Perhaps if the tap was inserted flush with the medial cortex of the fibula then stressed in the sagittal plane, the technique would be more reliable?

References

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Use of inner versus outer wall for assessing abdominal aortic aneurysm size

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COMMENT ON

Thapar A, Cheal D, Hopkins T, Ward S, Shalhoub J, Yusuf SW. Internal or external wall diameter for abdominal aortic aneurysm screening? *Ann R Coll Surg Engl* 2010; **92**: 503–505.
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We read the article by Thapar *et al.* with interest and have a number of concerns regarding the methodology used in their study.

From the article, it is not clear whether the clinical vascular scientists who took part were formally trained in the two methods of aorta/aneurysm diameter measurements. If the vascular scientists had a preference for one method of measurement in their routine practice, then this would bias the outcome of their measurements. Sonographers in the NHS Abdominal Aortic Aneurysm Screening Programme (AAASP) undergo formal training and the issue of placement of measurement calipers (particularly in identifying thrombus where confusion can arise) is carefully addressed. Therefore, it would be more valid if