that cell salvage is still financially viable, even setting aside other benefits.

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Minimising the risk of extensor pollicis longus rupture following volar plate fixation of distal radius fractures: a cadaveric study

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COMMENT ON

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I read the above article with a great deal of interest. Tendon attrition resulting from iatrogenic damage with either drills or screws during distal radial fracture fixation is of course a concern. I commend the authors for producing an insightful paper in a clinically relevant area, given the recent expansion in the proportion of distal radial fractures being aggressively treated with osteosynthesis.^{1,2} However, a number of concerns still exist.

Trying to predict which holes may present an increased risk of soft tissue damage is difficult and perhaps not as easily reproducible as suggested. This may be influenced by a number of factors including the precise implant position, screw width and screw length. Both the radial to ulnar and proximal to distal position of the plate may be altered depending on the fracture configuration, changing the position of the holes in relation to the extensor pollicis longus (EPL) tendon. In their cadaveric model, the authors used 1.6mm K-wires to assess EPL damage. The distal locking screws of the plates examined range from 2.3mm to 2.5mm. Would using the actual screws not have provided a more accurate picture of tendon injury? To avoid damage, the authors recommend leaving these centrally placed screw holes empty. This, however, may significantly compromise fracture stability, especially in the punch or coronal split fracture patterns.

Judging when the drill has penetrated the far cortex can be problematic, particularly with dorsal comminution. Drilling carefully with a finger underneath the dorsal lip of the radius provides adequate proprioceptive feedback to allow the surgeon to gauge the position of the drill tip accurately, avoiding soft tissue damage. Fluoroscopic assessment of

screw length, utilising views tangential to the radiocarpal surface in multiple planes, has been described to help with implant positioning and to avoid extensor compartment irritation.^{3,4}

With a rapidly expanding market of volar plating systems, including new fragment-specific polyaxial locking plates, the authors remind us of the importance of respecting the soft tissue envelope when treating this common orthopaedic injury.

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Stressing the need for rapid referral of complex open fractures to a specialist centre

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Guidelines from the British Orthopaedic Association and British Association of Plastic, Reconstructive and Aesthetic Surgeons recommend the immediate referral of complex open fractures of the lower limb to a specialist centre for combined orthopaedic and plastic surgical management.¹ However, Townley *et al* reported that across a large area of South-West England the mean delay in referral of open tibial fractures was 5.4 ± 1.7 days.²

Our institution is a regional referral centre providing free tissue transfer for a population of 3 million people. A 2-year retrospective audit of open fractures requiring soft tissue coverage ($n=22$) revealed a median referral delay of 3.5 days and there was no increase in the proportion of patients admitted directly to our centre (as opposed to having initial debridement $\pm$ fixation in a district hospital) following guideline introduction. Furthermore, the infection rate for indirect admissions was 33% compared with a reported rate of 3% when fixation and flap coverage are performed at the same sitting.³

With the establishment of regional trauma networks across the UK over the coming months,⁴ it is imperative that all surgeons dealing with open fractures are aware of the need for rapid referral and local mechanisms are in place to allow this to happen.