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

Perry DC, Machin DM, Casaletto JA, Brown DJ. Minimising the risk of extensor pollicis longus rupture following volar plate fixation of distal radius fractures: a cadaveric study. *Ann R Coll Surg Engl* 2011; **93**: 57–60
doi 10.1308/003588411X12851639107151

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.

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Straight to colonoscopy: the ideal patient pathway for the 2-week suspected cancer referrals?

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COMMENT ON

Beggs AD, Bhate RD, Irukulla S *et al*. Straight to colonoscopy: the ideal patient pathway for the 2-week suspected cancer referrals? *Ann R Coll Surg Engl* 2011; **93**: 114–119
doi 10.1308/003588411X12851639107917

In order to meet two-week referral targets for patients with colorectal symptoms, trusts must provide an efficient and effective patient pathway. On the face of it, the paper by Beggs *et al* suggests an attractive model for streamlining the process and potentially lowering costs. However, when one considers factors other than efficiency and cost effectiveness, the pathway may appear less than ideal.

In the straight-to-colonoscopy pathway described, patients are sent full bowel preparation with instructions. In response to a number of adverse incidents, the National Patient Safety Agency has published clear guidelines for the use of bowel cleansing solutions.¹ These include the need for clinical assessment to be undertaken by the clinician responsible for the procedure to ensure no contraindication or risks from their use. By the time a patient on a straight-to-colonoscopy pathway first sees the clinician responsible he or she will have already taken his or her bowel preparation. This is too late for an assessment of risk and an explanation on the safe use of the product.

A second but related concern pertains to consent. Guidelines for obtaining informed consent are widely circulated by the General Medical Council² and Department of Health.³ For elective procedures it is generally considered good practice to seek the patient's consent well in advance, with the clinician checking before the procedure starts that the person still consents. If a person is not asked to signify his or her consent until just before the procedure is due to start, at a time when he or she may be feeling particularly vulnerable, there may be real doubts as to its validity.

While it remains important to meet targets and continue to improve the efficiency of our service, we would caution colleagues in the potential for compromise in the quality of that service.

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Author's response

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We thank Fallis *et al* for their observations on our pathway and paper. To answer their specific points, this study was carried out before the National Patient Safety Agency (NPSA) alert was issued. However, our patients collect their bowel preparation from a nurse at the endoscopy unit prior to the procedure. Patients are asked by the nurse whether they have any potential contraindications to bowel preparation as discussed in the NPSA guidance.¹ After the NPSA alert was issued we also changed the referral form so that general practitioners are prompted to answer questions about co-morbidities and to request a blood test that will be available on the computer system when the patient attends the nurse appointment to collect the bowel preparation. If there is any potential problem, the case is discussed with an endoscopist present within the endoscopy unit and the preparation is given only if it is safe to proceed.

With regards to Fallis *et al*'s second point pertaining to consent, patients are sent a booklet describing the risks and benefits of colonoscopy at the time the appointment is booked. Patients are also specifically informed that they can discuss the procedure or raise any concerns either when collecting the bowel preparation or immediately before the procedure. We feel that this ensures valid consent as recommended in the General Medical Council and Department of Health guidelines.^{2,3}

In summary, we feel our pathway allows rapid access to the gold standard diagnostic investigations in an appropriate, safe and timely fashion.

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