Review of a smartphone app: *Clinical Orthopedic Exam*

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Clinical Orthopedic Exam is a smartphone application by www.clinicallyrelevant.com available for iPhones, Android™ phones and iPads. It details every clinical orthopaedic test. For each test there is a summary of the anatomical basis of the test, its purpose and instructions on how to perform the test. It has the statistics for sensitivity and specificity, with hyperlinked references to papers that have studied the test. Finally, there is a link to YouTube for every test to see a video on how to perform the test. It costs £24. In my opinion this app is essential for anyone studying for the FRCS(Orth) examination. Even established consultants could learn from it. Highly recommended.

Plastering the thumb

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COMMENT ON

McBride TJ, Rand B, Simons AW. Plastering the thumb. *Ann R Coll Surg Engl* 2011; **93**: 255
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McBride *et al* describe an innovative method that simplifies plaster immobilisation of the thumb but could be improved by limiting the distal extent of the dressings to allow unrestrained mobilisation of the finger metacarpophalangeal (MCP) joints. Although the plaster component of the dressing appears to stop at the MCP joint crease of the index and middle fingers (Fig 3 of McBride *et al*'s technical note), the wool and crepe dressings extend well beyond the MCP joint crease on all rays (Fig 4 of McBride *et al*'s technical note). This is unnecessary and impedes flexion of the MCP joint, which may ultimately cause stiffness and a reduced range of motion.

Thy3 cytology: what to do next?

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COMMENT ON

Lakhani R, Thomas Rourke, Jefferis A, Perry L, Ghiacy S, Wood S. Thy3 cytology: what to do next? *Ann R Coll Surg Engl* 2011; **93**: 225–228
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The correct management of patients with Thy3 lesions is challenging. The work-up of any patient requires full and appropriate clinical evaluation, which may include biochemical tests, thyroid auto-antibodies, ultrasound, radioisotope scan and/or other imaging before deciding on an appropriate management plan. The majority of the lesions in the Thy3 category are follicular neoplasms and the majority are likely to be recommended to undergo diagnostic hemithyroidectomy.

One of the themes of the paper by Lakhani *et al* is the difficulty in decision making when dealing with this subgroup. Lakhani *et al* have summarised the British Thyroid Association guidelines introduced in 2007 and the American Thyroid Association guidelines for the management of the thyroid nodules and lumps. However, they have not mentioned the recent guidance on the reporting of thyroid cytology specimens from the Royal College of Pathologists published in 2009.¹ This subdivides the Thy3 category into Thy3f (follicular) and Thy3a (atypia) instead of Thy3(i) and Thy3(ii). Use of the 'f' or 'a' suffix is intuitively easier to understand rather than the arbitrary 'i' or 'ii' and if incorporated into regular clinical use may help lessen the decision making burden that Lakhani and colleagues describe.

References

1. Cross P, Chandra A, Giles T *et al*. *Guidance on the reporting of thyroid cytology specimens*. London: Royal College of Pathologists; November 2009.

Author's response

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The Royal College of Pathologists guidance to use Thy3a and Thy3f, instead of i and ii respectively, has been taken up by our department and this classification is what we currently use. I agree that this change makes the subdivision of Thy3 easier to understand.