Letters and comments

Treatment of infected metalwork in orthopaedic patients

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doi 10.1308/003588413X13629960046354

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COMMENT ON

Norris R, Chapman AW, Krikler S, Krkovic M

A novel technique for the treatment of infected metalwork in orthopaedic patients using skin closure over irrigated negative pressure wound therapy dressings. *Ann R Coll Surg Engl* 2013; **95**: 118–124.
doi 10.1308/003588413X13511609957254

I read with interest the article by Norris *et al.* The reported results seem encouraging but I find it difficult to understand what this study adds to previous work. The use of 'conventional' negative pressure wound therapy (NPWT) dressings for treatment of infected metalwork has been described previously with similar success rates. The technique described here has three deviations from this widely accepted standard: the addition of a novel irrigation system, the substitution of wide pore foam for hydrophilic polyvinyl alcohol foam and the return of the patient to theatre for change of dressing under anaesthesia.

It is not clear what advantage is conferred by the addition of these adjuncts to this well established NPWT technique. The irrigation system may, in fact, be disadvantageous to the patient as it necessitates a protracted inpatient stay whereas a conventional NPWT system allows the patient to be treated in the community. The undertaking of regular dressing changes in theatre under general anaesthesia might confer an advantage in that repeat debridements would have been possible while further contamination of the metalwork was avoided. Although the use of the polyvinyl foam has a theoretical advantage of decreased bacterial load, was this borne out in reality?

By changing three variables at once without the use of a control group, it is difficult to draw meaningful conclusions from this study, and hence justify the increased cost and inconvenience involved. Nevertheless, it is a promising piece of work and I await with anticipation further research by this group.

AUTHOR'S RESPONSE

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Thank you for your kind letter regarding our article. We feel that you have made some very valid points about us making a number of small changes to the 'conventional' NPWT dressings for treatment of infected metalwork.

We acknowledged in our paper that one of the disadvantages of our technique was an increased inpatient stay. We agree that changing the dressings in theatre under general anaesthesia allows serial debridements of the wound and helps prevent secondary contamination. We cannot confirm whether or not the polyvinyl foam actually decreased bacterial load as we did not carry out microbiological testing of the foam at every dressing change.

However, we feel that the primary difference in our technique is that of skin closure over the NPWT dressing, which we believe confers a number of significant advantages. This creates a biological seal, which helps prevent leakage and therefore secondary contamination of the metalwork as well as facilitating better functioning of the NPWT equipment. It also prevents retraction of the wound edges, which makes final wound closure easier, once the NPWT dressing is removed, and therefore reduces the chance of further wound healing complications.

We hope that this letter clarifies the main messages of our paper. If there is anything else you would like to discuss, please do not hesitate to contact us.