this procedure can salvage many patients of renal failure before definitive therapy can be offered.

References

1. UNICEF. The State of the World Children 2008:Child Survival. New York:UNICEF;2008. Available at <http://www.unicef.org/swoc2008>. Accessed Aug 07,2008.

Iatrogenic Amputation of the Great Toe

Dear Sir,

A pre-term, second-born triplet female baby weighing 1.4 kilograms was delivered in a private hospital at a metro city. The baby developed features of hyaline membrane disease. She was on ventilator and intensive monitoring at neonatal intensive care unit (NICU) just after birth. The pulse oximeter probe was wrapped around the great toe of the left foot and for three days, the position of the probe was not changed (This was as told by mother, not confirmed by personal communication or verification). Meanwhile, parents could not afford the cost of treatment at the private hospital, hence baby was transferred to a government hospital for further management. Baby was shifted in a transport incubator with oxygen and ventilatory support. On arrival at the government hospital, the pulse oximeter probe was removed. The great toe that was completely hidden under the broad strap of pulse-oximeter probe had totally become gangrenous! The probe was very tight at base of the toe as evidenced by a constriction ring and clear demarcation between viable and non-viable zone. Over the next few days, the gangrenous toe shrank and fell off on its own. (Fig. 1). The baby made uneventful recovery is presently 20 month old and thriving well.

This case highlights the need for careful monitoring for complications related to devices used in medical care. Our heart sank for a while when the mother said “ Sir, God was kind to us, it was not thumb, it was only a toe which does not matter much”. Every parent may not be as forgiving as this in the present era of consumer protection act !

Mid- Clavicular Fractures- A Change in Treatment Strategies?

Dear Editor,

The author of the original article “Primary Plating of Displaced Mid-shaft Clavicular Fractures” published in July 2008, must be congratulated and commended for drawing the attention of the Armed Forces medical community to the rapid changes occurring in the well established traditional treatment of one of the commonest fractures of upper limb.

However, I have my concerns about the author’s technique of superior placement of plates in clavicle fractures. The main blood supply of middle third of clavicle is periosteal which is predominantly from superior and anterior borders [1]. Superior plating is likely to disturb this already tenuous blood supply increasing risk of non-union. In addition, the serving soldiers have to wear shoulder straps and the prominent hardware irritates the overlying skin and soft tissues leading to frequent requirement of another surgery for implant removal. Antero-inferior placement of the plate will offer an alternative in form of stable bony fixation, relatively much lower incidence of implant prominence problems and sharp instrumentation directed away from potentially risky

2. Srivastava RN, Bagga Arvind. Renal replacement therapy. In: Srivastava RN, Bagga Arvind ,editors. Pediatric Nephrology. 3rd ed. New Delhi: Jaypee Brothers 2001; 256.

Contributed by

Lt Col AK Simalti

Graded Specialist (Paediatrics), 155 BH, C/o 99 APO.

Fig. 1 : Picture showing amputated great toe of the left foot due to a constricting pulse oxymetry monitoring probe.

Contributed by

**Surg Cdr KM Adhikari*, Wg Cdr V Venkateshwar*,
Gp Capt D Singh#**

*Classified Specialist (Pediatrics), INHS, Asvini, Colaba, Mumbai.

*Reader (Dept of Pediatrics) AFMC, Pune, # Senior Advisor (Pediatrics & Neonatology), Command Hospital (AF), Bangalore

infraclavicular structures [2].

The author has used reconstruction plates for fixation when they do not offer adequate biomechanical stability and strength. Contoured LC-DCPs would offer a biomechanically better implant choice [3]. The use of postoperative drains is also extremely controversial. It has been proven beyond doubt that use of postoperative drain increases the risk of infection. There is no firm basis for the use of drain available in literature [4].

I do not agree with the author’s contention that the literature relating to pin fixation of clavicle fractures is rare. There is enough emerging literature that supports intra-medullary fixation as an alternative to plate or screw fixation or nonsurgical treatment, as it produces excellent cosmetic and functional results regardless whether patients suffered from isolated clavicular fractures or polytrauma [5 - 7]. It may be noted that these studies have much larger patient groups and longer follow-ups.

I would not be in a hurry to reach a conclusion based on this study in view of the small study group i.e. only 20 patients. The