

We would like to thank Sadri and colleagues for a very interesting paper that draws attention to a very important part of our practice. Nevertheless, there does appear to be a potential vulnerability with the source document they were working from and we would welcome wider views from college members concerning the safe upper limit for tourniquet times in the upper and lower limbs.

Testing the distal tibiofibular syndesmosis – Comment 1

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COMMENT ON

Rajagopalan S, Upadhyay V, Taylor HP, Sangar A. New intra-operative technique for testing the distal tibiofibular syndesmosis. *Ann R Coll Surg Engl* 2010; **92**: 258
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I read with interest the technical note on testing the distal tibiofibular syndesmosis and thought it a clever technique. I have used it on occasions since and found it simple and effective. I would, however, like to point out to anyone else trying this technique that, in the two figures included in the publication, the medial malleolus fracture had not been fixed prior to testing the syndesmosis, which is obviously necessary. It is not possible to put widening of the clear space down to syndesmotom injury in the absence of intact medial structures.

Comment 2

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The authors describe an alternative method for assessment of the integrity of the distal tibiofibular syndesmosis. In their description of the technique, they highlight the importance of fixation of the fibular fracture prior to performing the test. However, they neglect to mention the importance of fixation of any associated medial malleolar fracture prior to testing syndesmotom stability. Indeed, the images accompanying the note show their test being performed on a bimalleolar fracture with the medial malleolar fracture untouched, but the final image shows medial malleolar fracture fixation and syndesmosis screws present. This is in contrast to conventional teaching. In

the majority of bimalleolar fractures, rigid fixation of both medial malleolar and fibular fractures should stabilise the syndesmosis and abolish the need for a syndesmosis screw.^{1,2} The exception to this is if there is co-existing ligamentous disruption medially or laterally, in which case syndesmotom widening would be observed on testing the syndesmosis after fixation of both medial malleolar and fibular fractures.

References

1. Boden SD, Labropoulos PD, McCowin P, Lestini WP, Hurwitz SR. Mechanical considerations for the syndesmosis screw. *J Bone Joint Surg Am* 1989; **71**: 1548–55.
2. Yamaguchi K, Martin CH, Boden SD, Labropoulos PA. Operative treatment of syndesmotom disruptions without use of a syndesmotom screw: a prospective clinical study. *Foot Ankle Int* 1994; **15**: 407–14.

The ‘defensibility’ of surgical injuries

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COMMENT ON

Skidmore FD. Guest editorial. *Ann R Coll Surg Engl* 2010; **92**: 271
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Scurr JRH, Brigstocke JR, Shields DA, Scurr JH. Medicolegal claims following laparoscopic cholecystectomy in the UK and Ireland. *Ann R Coll Surg Engl* 2010; **92**: 286–291
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I note the Editorial and linked paper on the ‘defensibility’ of surgical injuries. The fact that 94% of vascular and biliary injury cases are settled out of court supports the contention that such injuries are difficult to defend. Presumably, the defendant solicitors were sufficiently impressed with the expert evidence adduced to make them disinclined to continue their defence. But could this merely reflect the resoluteness of expert advice, if all 61 ‘winning’ opinions came from the same expert, creating a self-fulfilling prophecy? We should know whether this was the case, before reaching a firm conclusion.

Skidmore’s concluding assertion that ‘laparoscopic procedures...when they go wrong are...indefensible’ requires more careful qualification. Scurr’s paper considers 83 non-vascular and non-biliary cases of which 56 (67%) were abandoned, and only 18 settled. These were therefore eminently defensible.

He also suggests that non-essential cosmetic surgery that causes harm is indefensible. This is quite wrong. Success in negligence requires proof of substandard care, together with a causative link between this and any harm that results. Neither the ‘essential’ character nor the ‘cosmetic’ nature of a procedure

has any bearing whatsoever on whether it can be defended during litigation. It is misleading to suggest otherwise.

Medicolegal claims and intra-operative cholangiography

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COMMENT ON

Scurr JRH, Brigstocke JR, Shields DA, Scurr JH. Medicolegal claims following laparoscopic cholecystectomy in the UK and Ireland. *Ann R Coll Surg Engl* 2010; **92**: 286–291
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The vast majority of this piece is sensible and reasonable. Predictably, perhaps inevitably, the authors move into troubled waters when they discuss intra-operative cholangiography (IOC). Is there an issue in gastrointestinal surgery that engenders more controversy or discord? Inevitably, participants in this debate quote evidence to support their own prejudice. It is true that ‘the routine use of IOC has been reported to reduce the incidence of bile duct injuries by clarifying the anatomy’.¹ It is also true that numerous national and international series have shown that the use of IOC is not associated with any reduction in the risk or rate of bile duct injury. However, the numbers in these series range between 5 and 70,000 whereas the Flum study already referred to involves 1.5 million procedures.

The authors make the statement: ‘an IOC should be used to confirm the anatomy if any doubt exists’. Is there any evidence to support this statement? The Flum paper demonstrates that when the ‘frequent cholangiographer’ (essentially a surgeon who attempts to perform routine IOC) performs a cholangiogram, a significantly lower incidence of bile duct injury results. This is unarguable. However, the other extremely interesting and seldom mentioned finding of this study is that if the ‘infrequent cholangiographer’ (arbitrarily set at less than 25% of cases but often much less than this) performs a cholangiogram, the bile duct injury rate, far from decreasing, significantly increases. The authors argue, I believe plausibly, that in this instance the cholangiogram was being done in a ‘difficult’ case.

So much for the evidence, what about logic/simple common sense. We have all been faced with a situation where we cannot confidently identify the anatomy in the area of Calot’s triangle. Let us analyse what performing a cholangiogram in these circumstances actually means. It involves selecting a bile duct, the identity of which (it is clearly conceded) is uncertain, putting two clips across it and making a hole in it. Is this justifiable or appropriate? I would argue absolutely not. The safe, and there-

fore the correct, approach in this situation is to dissect the gallbladder, fundus first, off the liver. This approach can sometimes lead to confident identification of the anatomy at the neck of the gallbladder but in my experience rarely. The sensible course of action is then to stay well clear of Calot’s triangle, amputate the gallbladder across Hartmann’s pouch, remove any stones and over-sew the remnant. It is, of course, possible to do this laparoscopically but many surgeons might prefer to employ open surgery and, if this is the case, they should convert without a moment’s hesitation. This approach has served me well for over 20 years, or just under 2500 procedures, with a bile duct injury rate of zero (so far, touch wood!).

The advice that cholangiography should be done if the anatomy is unclear is supported by no convincing evidence, is not sensible or logical and should be ignored by all surgeons, particularly those in training.

Reference

1. Flum DR, Dellinger EP, Cheadle A, Chan L, Koepsell T. Intraoperative cholangiography and the risk of common bile duct injury during cholecystectomy. *JAMA* 2003; **289**: 1639–44.

AUTHORS’ RESPONSE

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James Manson raises an interesting point. Is operative cholangiography more likely to increase the incidence of bile duct injury?

The role of intra-operative cholangiography does remain controversial. As stated in our article, the use of intra-operative cholangiography does not guarantee prevention of a bile duct injury. We also state that: ‘If safe dissection can no longer be performed laparoscopically, the surgeon should convert to an open procedure’. The same surgical judgment is also required when deciding if performing intra-operative cholangiography can be done safely or risks making the situation worse. James Manson’s approach for the scenario he describes is sensible and the points he makes are valid.

In response to Robert Wheeler’s question regarding the ‘resoluteness of expert advice’ in the cases that were settled out of court. These settlements would have been based on the opinion of more than just one expert witness and included opinions given by general surgeons, hepatobiliary surgeons and professors of surgery. In cases that did not proceed, it is likely that only a single opinion may have been sought. However, we are unable to tell if these claimants tried to/succeeded in pursuing action through a different legal team.