

Correspondence

Can the Ottawa Ankle Decision Rules Be Applied in the United States?

TO THE EDITOR: In the January 1996 issue of THE WESTERN JOURNAL OF MEDICINE, Leslie Milne, MD, of San Diego, California, advises us to go by the Ottawa Ankle Decision Rules to avoid taking unnecessary ankle x-rays.¹

In our community, this is folly. Anyone who has been in practice for a while knows that the reason we take these x-rays is legal, not medical. I am sure the Ottawa Ankle Decision Rules were known to Hippocrates and everyone who followed him. In Canada, the legal system does not have a contingency fee, nor are physicians necessarily subject to the scrutiny of a jury of their "TV-literate, question-oxymoronic" peers on matters that they cannot comprehend.

We live in a nation whose legal system serves by and large, to paraphrase a famous attorney, "a nation of attorneys, by attorneys, and for attorneys" and that has established a legal system whereby lawyers get a share of any action, necessary or not. Anyone who shows up at an emergency department with an ankle complaint darned well better get x-rays, or the physicians will pay if they don't have them taken.

Anyway, what's all the fuss? A \$50,000 fluoroscan machine can give a reading in a twinkling. It costs \$30,000 to process any single claim, whether anything comes of it or not, according to our malpractice carrier. My advice: Buy a fluoroscan, photograph all symptomatic ankles, take x-rays of them all, and have them documented. Let the Canadians practice medicine under their legal system, and don't try to tell us how to practice it under our legal system.

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REFERENCE

1. Milne L: Ottawa ankle decision rules (Epitomes in Emergency Medicine). West J Med 1996; 164:67

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Dr Milne Responds

TO THE EDITOR: My article on the Ottawa ankle rules was merely a summary of the current literature on the subject, not necessarily a recommendation for anyone practicing in a given community. As an emergency physician in California, however, I have found these rules to be helpful. My approach is to explain to patients why I do not think they need a radiograph, particularly if it will not change how I treat them even if there is a small fracture. Then I let them make the choice. I would estimate that they request the film a little less than half the time. I always document on the chart why I did or did not get the radiograph and now refer to the Ottawa rules.

It is my hope that the medical profession is making a greater effort to standardize medical care in a fiscally responsible way in the United States. These ankle rules are a perfect example of a highly sensitive tool that is helpful in safely limiting costs. In our emergency department, I do not order a head computed tomographic scan on every patient with a headache, nor do I radiograph the cervical spine of all motor vehicle accident victims if the results of the history and physical examination do not give me cause for concern. Both of these areas run an even greater liability risk than a missed ankle fracture, but I think I must use some judgment, supported by the literature, in practicing medicine.

Certainly anyone can "sue" for anything anytime, and they do. The question is, "Do they have a legitimate case?" In malpractice claims, plaintiff patients must show that defendant physicians breached the standard of care and that that breach caused an alleged injury. Because the Ottawa Ankle Decision Rules are now considered, at least by some, the standard of care for ankle injuries, proper documentation of why the radiograph was not obtained should stand a physician in good stead in any legal action.

From a financial aspect, health maintenance organizations are relying on standards of care to help them determine which charges should be reimbursed. My guess is that in the not-too-distant future, these agencies will demand documentation of the need for radiographs in simple ankle sprains. Certainly the radiographs are not dangerous, but are they necessary?

LESLIE MILNE, MD
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The Role of Hyperbaric Oxygenation Therapy for Necrotizing Fasciitis

TO THE EDITOR: The case report on necrotizing fasciitis in the October 1995 issue raises three concerns.¹ First, we are not convinced that the *Vibrio* organism was a pure isolate from the necrotizing fasciitis wound. The presentation of the bacteriologic data suggests that it may be, but is vague enough to leave this question in doubt. More likely, and as is usual, cultures from a specimen of necrotizing fasciitis grow mixed flora. Consequently, we question whether this case can truly be classified as a pure fulminant *Vibrio cholerae* non-O1 necrotizing fasciitis.

Second, the authors considered the patient to be immunocompetent. Although this may be a matter of definition, there is little question in our minds that this patient was a "compromised" host with underlying diabetes mellitus, previous foot operations, previous episodes of cellulitis, and a chronically infected ipsilateral foot wound. Patients with wound infections by non-O1 *V cholerae* frequently have underlying diseases (such as diabetes).^{2(p1488)} The importance of this information is that a patient with compromising host factors, presenting as the patient in

this case report did, should be suspected of having a necrotizing soft tissue infection. Surgical intervention at the time of presentation—exploration, decompression, and debridement—may have prevented the ablative operations. The patient's response to interventions was what we would expect from a compromised host—that is, slowly healing wounds, extended antibiotic coverage, and additional operations.

Finally, the authors fail to mention the role and apparently did not consider the use of hyperbaric oxygenation (HBO) therapy as an adjunctive intervention in the management of this patient's necrotizing fasciitis. Reviews indicate mortality rates decrease by 50% when HBO is used as an adjunct.^{3,4} Our own experiences have shown similar benefits. Of equal importance, the incidence of major amputations (such as leg, forearm, or entire limb) has almost been totally eliminated when we use HBO as an adjunct to the surgical and medical management of necrotizing fasciitis. In addition, the need for multiple surgical debridements is greatly reduced with the usual situation of only one additional in-operative department debridement after the initial exploration, decompression, and debridement. A third return to the operating department is usually for definitive coverage and closure of the wound. Regardless of the etiologic agent, we recommend HBO be used for necrotizing soft tissue infections, especially in a compromised host.

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REFERENCES

1. Wagner PD, Evans SD, Dunlap J, Ballon-Landa G: Necrotizing fasciitis and septic shock caused by *Vibrio cholerae* acquired in San Diego, California. *West J Med* 1995; 163:375-377
2. Stein JH (Ed): Other pathogenic vibrios. *In Internal Medicine*, 3rd edition. Boston, Mass, Little, Brown, 1990
3. Hyperbaric Oxygen Therapy—A Committee Report. Bethesda, Md, Undersea and Hyperbaric Medical Society, 1992, UHMS publication No. 30 CR(HBO), pp 38-43
4. Riseman JA, Zamboni WA, Curtis A, Graham DR, Konrad HR, Ross DS: Hyperbaric oxygen therapy for necrotizing fasciitis reduces mortality and the need for debridement. *Surgery* 1990; 108:847-850

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Dr Ballon-Landa Responds

TO THE EDITOR: Drs Strauss, Chung, Hart, and Weinstein bring up several interesting points. We wholeheartedly agree that hyperbaric oxygenation (HBO) therapy is a valuable adjunct in the treatment of necrotizing fasciitis caused by any agent and would have been of value in our patient, had it been available. We have previously reported on the use of this modality in such a case, wherein *Aeromonas hydrophila* was the pathogen.¹ Unfortunately, the hyperbaric chamber in our hospital, which was the

first one in a civilian hospital in San Diego County, was a casualty of the difficult economic times that have befallen our institutions, and currently HBO is not readily accessible to us or to most of our colleagues.

Bacterial synergism is seen in a majority of cases of this syndrome, and clinicians must diligently look for evidence of mixed infection. We did and found none. The surgical specimens of the necrotic tissue were carefully cultured for aerobes, anaerobes, fungi, and acid-fast bacilli, and the results were a pure culture of non-O1 *Vibrio cholerae*. We expected that we would have recovered other organisms from the necrotic material, as has been our experience, if they were there. Two different laboratories confirmed this organism's identity. This organism seems to have acted alone in the fascial planes.

Our patient had intact cellular and humoral immunity, as measured by the usually available tests. Whereas his immune system was competent, we agree that he was, by virtue of his diabetes, previous infections, and previous operations, a compromised host at increased risk of infections developing.

Everybody agrees that the sooner the diagnosis is suspected, the sooner patients will arrive at surgical debridement and, in turn, the better the chance for salvage. Every experienced clinician also realizes, however, that its recognition can be extremely difficult in the earliest hours, as it was in our patient. Medical science is currently in need of a diagnostic test that will more accurately predict which patients with early absent or equivocal clinical signs will benefit from surgical therapy and which will not.

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REFERENCE

1. Hennessy ALT, Ballon-Landa GR, Jones JW, Farrell T: *Aeromonas hydrophila* gas gangrene: A case report of management with surgery and hyperbaric oxygenation. *Orthopedics* 1988; 11:289-293

Latino Belief of Alleged Medical Procedure

TO THE EDITOR: Various studies have described specific Latino beliefs that may have implications for medical practice, for example *empacho* ("intestinal obstruction"), *mollera caida* ("fallen fontanelle"), *ataques de nervios* ("nervous attack"), and *susto* ("fright," "shock").^{1,4} We became aware of the possibility of another highly unusual belief that can affect medical professionals involved in newborn care. It is thought, according to Latino informants, that during the post-neonatal examination, physicians perform a procedure that entails "cutting," "opening," or "breaking" the hymens of newborn female infants.

To find out how widespread the belief is, we interviewed 105 Latino (Mexican, Mexican American, Guatemalan, and El Salvadoran) patients and health care professionals at a community clinic in El Cajon, California. Spanish- and English-language question-