



Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the Notice printed on the inside back cover. Tables and figures should only be included if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and to subedit contributions to ensure clarity.

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Response to paper by Morris Stiff et al.

Training in the Calman era: what consultants say

Morris Stiff GJ, Clarke D, Torkington J, Bowrey DJ, Mansel RE.

Ann R Coll Surg Engl (Suppl) 2002; **84**: 345–7

Dominic Nielsen, David Ricketts

Department of Orthopaedics, Princess Royal Hospital, Haywards Heath, Sussex, UK

The data of this article¹ summarise the subjective opinion of 74 consultants. Collectively, dissatisfaction with many aspects of Calman training was expressed. Calman training, however, is here to stay. To improve it, we need positive suggestions based on objective data. It follows that this article would have been more helpful had it placed greater emphasis on assessing the surgical ability and experience of trainees and suggesting means of improvement.

Regarding training, we note that some of the specialist surgeons surveyed received no training in their specialist interest. Calman training allows for one or more years in specialist training. We agree that Calman training is short in general training and experience but these data suggest with 'Calmanisation' an improvement in the minimum period of specialist training has occurred.

Regarding the exit examination, the statement that 'the majority of the respondees felt that such an exam should not be necessary' is not supported by the data shown. Of the 69 replies, 45 (65%) were in favour of an exit examination.

Reference

1. Morris Stiff GJ, Clarke D, Torkington J, Bowrey DJ, Mansel RE. Training in the Calman era: what consultants say. *Ann R Coll Surg Engl (Suppl)* 2002; **84**: 345–7.

Correspondence to: Dominic Nielsen, Department of Orthopaedics, Epsom Hospital, Epsom, Surrey, UK. E-mail: domnielsen@hotmail.com

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Response on behalf of the authors

GJ Morris Stiff

In reply to the letter by Nielsen and Ricketts, I would like to address the points raised. First, our article was never intended to provide a solution to Calman training but simply to document what a cohort of surgeons within a defined region felt about the imposition of Calman training and the effects it has had to date on surgical training. As there was no consultation prior to its introduction, it is not surprising that not all consultants were happy with the process. The effects of Calman training are now being dwarfed by the introduction of the EWTD, again without consultation. Should the profession not speak its discontent rather than be forced against its will to adapt?

Some of the consultants included in the survey were trained in the 1970s and 1980s before the era of sub-specialisation. Their training was significantly longer and they received a broad training in general surgery and hence did not regard themselves as being trained within a particular sub-speciality. In the Calman system, trainees are supposed to receive 1 or more years of specialist training but this can only be done if there are opportunities exist within their region and thus not all trainees can train within their area of interest. Therefore, Calman is not necessarily better in this regard.

I concede that the word 'majority' was inappropriate and that 'a significant proportion' would have been a more appropriate term. There were numerous comments made in freetext (not included in the paper) to the effect that the exit examination was only required because it was felt that training was now inadequate and needed to be verified by means of examination.

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*Response to paper by DJ Bowrey, MI Otter,
PJ Billings*

Rectal infiltration by prostatic adenocarcinoma: a report on six patients and review of the literature

Ann R Coll Surg Engl 2003; **85**: 382–5

N Hon, N Lynn, TF Chen

Department of Urology, Alexandra Hospital, Redditch, UK

We note that the majority of surgically treated patients in this review ended up with a colostomy. Most patients are elderly with a limited life expectancy and a defunctioning colostomy may be difficult to manage. An alternative palliative option is transanal resection of the prostate which was not mentioned in the paper.¹ This is a simple, well-tolerated, minimally invasive procedure, which may prevent the need for a laparotomy or stoma, with resultant satisfactory palliation of obstructive symptoms for the remainder of the patient's life.

Reference

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Correspondence to: N Hon. E-mail: nicolahon@btinternet.com

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*Response to a Technical Note by CG Wallace,
JNA Gibson*

Mobile messaging: emergency image transfer

Ann R Coll Surg Engl 2004; **86**: 42–3

D Wallace, C Durrant

*Department of Plastic Surgery, Queen Victoria Hospital,
Holtye Road, East Grinstead, UK*

We read this article with interest and agree with the potential benefits of early input by senior colleagues reviewing digital radiographic images. However, we have several concerns about the use of multimedia messaging service (MMS) technology.

For medicolegal purposes, an accurate audit trail and documentation are essential. Therefore, we have found that encryption allows accurate data labelling. Otherwise the risk of confusion is considerable, which may have significant sequelae, especially for a system in use in the acute setting.

We have significant concerns over the mobile phone screen, with a maximum resolution of only 160 x 120 pixels. The American College of Radiologists introduced minimum requirements are 512 x 512 pixels for low and 2000 x 2000 pixels for high definition needs, otherwise fractures are missed.¹ Also, the confidence in diagnosis is lost before a loss in resolution is perceived by the clinician.² Therefore, there is a real risk of missing important findings.

A further problem is that mobile phones cause electromagnetic interference at a level that leads to confusion as to whether or not their use should be promoted or restricted within hospital.

We commend the authors for the application of new technology, but would caution that further adequate evaluation is mandatory prior to the introduction into routine clinical communication.

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2. Briggs R, Bailey JE, Eddy C, Sun I. A methodologic issue for ophthalmic telemedicine: image quality and its effect on diagnostic accuracy and confidence. *J Am Optom Assoc* 1998; **69**: 601–5.

Correspondence to: Mr D Wallace, 54 Quinton Street, Earlsfield, London SW18 3QS, UK. Tel: +44 (0)7984 830415; Fax: +44 (0)20 8642 5997; E-mail: davidandvix@aol.com & david.wallace@nhs.net

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Response to paper by YC Chan et al.

Abdominal complications from crack cocaine

Ann R Coll Surg Engl 2004; **86**: 47–50

Paul R Maddox, Damian Gardner-Thorpe

Directorate of Surgery, Royal United Hospital, Bath, UK

We would commend the authors for highlighting what may, unfortunately, become an increasing problem presenting to the general surgeon on call, due to the increasing drug abuse of crack cocaine. Idiopathic pneumoperitoneum may be expected as an uncommon sequelae of chest trauma due to Valsalva manoeuvre with or without attendant ventilation¹

but for pneumoperitoneum to be spontaneously induced with a Valsalva manoeuvre is somewhat surprising as animal studies have shown really quite high intratracheal pressures are required to produce pneumomediastinum leading on to pneumoperitoneum.^{2,3} Presumably, this patient must have a prolonged and repeated Valsalva manoeuvre to attain the high pressure gradient required.

The problem for the clinician is being sure that there is not an intra-abdominal surgical cause for the pneumoperitoneum but, while one must have a low threshold to proceed to laparoscopy/laparotomy if there is any doubt, we would agree this is a situation where non-invasive investigations might well avoid the need for laparotomy using contrast studies, possibly coupled with simple laparoscopy.

References

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3. Macklin D. Pneumothorax with massive collapse from experimental local overinflation of the lung substance. *Can Med Assoc J* 1937; 36: 414–20.

Correspondence to: Paul R Maddox, Consultant General Surgeon, Royal United Hospital, Coombe Park, Bath BA1 3NG, UK. E-mail: paul.maddox@ruh-bath.swest.nhs.uk

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Responses to paper by AM Khan et al.

Hip osteoarthritis: where is the pain?

Ann R Coll Surg Engl 2004; 86: 119–21

Letter 1

Rebecca Payne

Department of Orthopaedics, Worthing Hospital, Worthing, UK

This paper raises the common diagnostic problem of differentiating between pain from the hip or the lumbar spine. However, as it was not specifically mentioned in the paper, I would like to know whether the 51 patients randomly selected from the hip replacement waiting list had lumbar pathology definitely excluded, as clearly this would distort their pain maps. Likewise, it would be useful to know whether the patients awaiting lumbar spine decompression had had hip pathology excluded. As the two conditions commonly co-exist, pain maps from these patients could reflect overlapping distributions of pain from both sources.

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It would also be interesting to know whether there was a change in the pain maps following surgery, which may also help clarify the source of the pain.

Correspondence to: Rebecca Payne, Department of Orthopaedics, Worthing Hospital, Lyndhurst Road, Worthing BN11 2DH, UK

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Letter 2

IJ Bissell, JR Morton, DC Chapple

Department of Trauma and Orthopaedic Surgery, Salisbury District Hospital, Salisbury, UK

We were interested to read this article eliciting that pain from hip osteoarthritis may manifest below the knee, explained by the authors by referral of pain along the saphenous branch of the femoral nerve.

It is not apparent from the article if the group of patients with hip osteoarthritis had degenerative lumbar disease, despite mentioning that patients may have combined hip osteoarthritis and lumbar spondylosis in their discussion. We recognise that the two diseases do co-exist.¹ In addition, the prevalence of radiological lumbar spine degeneration is as high as 70% in the elderly.² Radiological hip osteoarthritis is relatively rare, peaking at about 10%, but less than 4% in the age group studied in the above article.² Of the population with radiological osteoarthritis about 50% are symptomatic.³

We are intrigued that the prevalence of anterior shin pain in hip osteoarthritis in this study approximately matches the prevalence of radiological lumbar spine degeneration in this age group, and that the prevalence of calf pain is half the prevalence of radiological lumbar spine degeneration. Did the authors control for this confounding factor?

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Correspondence to: Mr DC Chapple.

E-mail: david.chapple@salisbury.nhs.uk

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*Response to a Technical Tip by JTK Lim,
A Acornley, RM Dodenhoff*

Displaced paediatric supracondylar fractures of the humerus – response to a sticky solution

Ann R Coll Surg Engl 2003; 85: 429

FA Carroll, SM Cockshott, CE Bruce

Alder Hey Hospital, Liverpool, UK

Paediatric supracondylar fracture is often difficult to manage and percutaneous fixation can be technically demanding. We would wholeheartedly agree with the use of surgical adhesive tape to maintain reduction of the fracture once reduced, especially if working as a lone surgeon.

In our experience at Alder Hey, we surgically treat on average 35–40 supracondylar fractures a year. We would advise meticulous patient selection with this technique so as not to fall into technical difficulties in situations where the arm has been locked with non-sterile tape and the reduction is then lost. Patients who fall into this category would include those with flexion injuries where taping the fracture would exacerbate the deformity in the sagittal plane, those with lateral column comminution which are inherently unstable using this technique and those who have been delayed arriving in theatre and are significantly swollen.

In these types of patients, we would recommend the use of two surgeons. A tourniquet is applied but not inflated. One surgeon holds the reduction and the other does the percutaneous fixation with a mini-open medial technique. The arm is abducted 90° and lies on an arm table. The C-arm is set up to rotate around the elbow. In this way, if closed reduction and fixation fails then the surgeon can move swiftly on to open reduction once the tourniquet has been inflated.

Correspondence to: Mr FA Carroll, 13 Gilbert Road, Hale, Cheshire WA15 9NR. E-mail: fa.carroll@virgin.net

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Response by the authors

We agree with the comments made, particularly the need to prepare for open reduction in case anatomical reduction cannot be achieved closed.

It is worth making the point that the method of reduction in our illustration applies to the most common

displaced variety – an extension supracondylar fracture with posteromedial displacement of the distal fragment. In the 10% of supracondylar fractures that are laterally displaced, forearm supination instead of pronation should be used to lock the reduction. The rarer displaced flexion supracondylar fractures (2–6%) clearly require extension during reduction and are stable in extension except for the atypical variety.¹ Fractures associated with significant swelling present increased difficulties, not least the inability to fully flex the elbow without compromising the circulation. Elevated straight arm traction until the swelling subsides or as definitive management² may be the best course here.

References

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Response to paper by HE Cohen et al.

Atypical giant cell arteritis resulting in arm amputation

Ann R Coll Surg Engl 2003; 85: 260–2

FH Zaidi¹, ER King²

1Imperial College London, London, UK

2College of Physicians and Surgeons, Columbia University Medical Center, Manhattan, New York, USA

We read the recent report of giant cell arteritis (GCA) by Cohen and colleagues with interest.¹ The case is very well-described, but we must differ over a key summary statement that their paper is ‘the first case reported as asymptomatic in an extracranial location with a normal ESR’. And this is so even if ‘asymptomatic’ is taken to mean absence of general symptoms of GCA, the authors noting that their patient had ‘symptoms arising from the ischaemic arm’. We are raising this issue as were this to be the only such case in the literature it would have very wide-ranging implications, as it would suggest that current understanding of GCA at the molecular level was at least partly erroneous, for the disease is related to how elastin is distributed within the arterial tree.

GCA closely follows the pattern of molecular elastin in tunica media and adventitia.² Intracranial and intradural arteries are extremely thin-walled with a thin tunica media

and adventitia – consequently there is very little elastin, with loss of definition of the internal and external elastic laminae on penetration of dura mater.² Further, matrix metalloproteinase-9 (MMP-9) in temporal arteritis specimens specifically localise to macrophages in regions of internal elastic lamina disruption, suggesting an autoimmune role for GCA.^{2,3} Also, elastin catalysis by leukocyte elastase in GCA can provide elastin-derived peptides that act as autoimmune targets for T cells.⁴ Elastin distribution (and by implication its autoimmune disruption) exerts a strong influence on the frequency with which GCA affects one of its most important locations – the intra-orbital arteries – where it involves in order of decreasing incidence the posterior ciliary arteries (which are extracranial and extradural), ophthalmic artery (extra- and intracranial) and the central artery of the retina (extracranial but intradural).² GCA of these vessels causes the dreaded complication of blindness through anterior or posterior ischaemic optic neuropathy, central retinal artery or cilioretinal artery occlusion, ocular ischaemic syndrome, or extra-ocular muscle palsies.^{5,6}

Owing to the amount of elastin in the posterior ciliary arteries, occult GCA (ocular GCA without any systemic symptoms and signs of arteritis) is common. Hayreh and colleagues found an incidence of over 21% in temporal artery biopsy-confirmed cases of GCA.⁷ Occult GCA has also been found with a normal ESR and CRP by Poole and colleagues.⁸ The latter case most probably involved posterior ciliary arteritis as the optic disc was not blurred, yet there were cotton wool spots. Like the case under discussion, there were no systemic features of GCA either.

It may be that the authors, in common with some other workers, have used 'extracranial' to mean arteries outside the head and/or neck regions.¹ Yet, anatomically, the cranium is defined as that part of the skull which houses the brain (Latin *cranium*, from Greek *kranion*), and this also has clinical significance as it represents an important transition from elastin-rich to elastin-poor arterial tissue.^{2,9} However, their case in question is not the first such case outside the head and neck even. Since the aorta is relatively elastin-rich compared with the subclavian artery, this is one reason why GCA is more likely to affect the aorta.^{2,4,9-11} Yacoub and colleagues have clarified that rapidly progressive aortic involvement in a previously asymptomatic patient may suggest GCA alongside other causes of a dilated aortic root.¹⁰ Further, a case has been reported of GCA, presenting with severe aortic regurgitation and a normal ESR with no specific systemic symptoms save chronic headache (authorities suggest that for a headache to be attributed to GCA with certainty it should be a change in headache or a headache of recent onset).¹²

Finally, a case of GCA involving the subclavian artery has been previously noted in a large study which included an 87-year-old female patient with an ESR of 19 mm/h at presentation – the authors' 69-year-old female patient had an

ESR of 26 mm/h.¹² Like the case in question, this patient also had no general symptoms of GCA and the only clinical manifestations were due to ischaemia of the upper limb, in this case a left subclavian bruit, absence of radial and ulnar pulses and a left digital ulcer. The ESR in the latter patient was most unlikely to have been a technical error for it paralleled the CRP.¹²

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Correspondence to: Mr FH Zaidi. E-mail: fhz12@hotmail.com

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Response from authors

We thank Zaidi and King for their interesting and detailed letter with regard to the immunocytochemistry of giant cell arteritis (GCA) in response to our case report. It is fair to say that we interpreted asymptomatic to mean free from the general symptoms of GCA. We also use, as others have, extracranial to refer to arteries outside the head and neck. It is not our intention, however, to review or question the existing molecular biology and we have no issue with the descriptions they provide. We take the perspective of a receiving general surgical intake. It is

reasonable to consider an acutely ischaemic arm to be embolic in origin. Having undertaken a balloon embolectomy which did not produce a satisfactory result, we have shown that it is feasible to transfer an anaesthetised patient safely to the radiology department where definitive angiography was performed. This enabled us to determine appropriate treatment rather than undertake a 'blind exploration' of a difficult surgical field. Second, the value of histology is highlighted. It can easily be overlooked in embolectomy. In our case, steroid therapy would not have been implemented and, although ultimately unsuccessful, a true diagnosis was reached and suitable treatment was used.

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Response to Technical Tip by A Abraham

Emergency treatment of ankle fracture dislocations – a reliable technique for early reduction

Ann R Coll Surg Engl 2003; **85**: 427

SS Kaleel

Department of Trauma and Orthopaedics, Alexandra Hospital, Redditch, UK

As a trainee in trauma and orthopaedics, I religiously follow the technical section in the journal. I was quite impressed with the simplicity, with which Abraham described the reduction of ankle fracture dislocation. I have practised this technique and it has never failed, well almost! Recently, a young man in his late teens, presented to casualty with a fracture dislocation of the ankle. Despite adequate analgesia and midazolam, the ankle would not reduce by closed means; subsequent closed attempts under general anaesthetic did not produce the desired result. The patient proceeded to have open reduction, and was found to have the tibialis posterior tendon interposed between the anterior distal tibia and the medial malleolus which was preventing closed reduction.

A literature search suggests there have been three case presentations with a similar clinical scenario.^{1,2} Ankle fracture

dislocations are one of the commonest injuries seen in the casualty department; most are amenable to closed reduction but there are occasions where patients needs urgent operative intervention to prevent skin, soft tissue, and neurovascular compromise. Reduction is also important in that it prevents, or at least delays, tissue oedema, which can have implications over future interventions.

References

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Correspondence to: SS Kaleel, SHO Trauma and Orthopaedics, 11B Blythe House, Alexandra Hospital, Redditch B98 7UB, UK.
E-mail: saajkall@aol.com

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Response to Technical Tip by C Hogg

Preparing digital images for publication

Ann R Coll Surg Engl 2004; **86**: 56

David T Loveday

Department of Orthopaedics, Arrowse Park Hospital, Wirral, UK

I agree with the author that macro mode is best suited for close up digital photography. However, I feel the most useful and most difficult field of digital photography of radiographs has been ignored. Radiographic films are best captured by a digital camera in black and white mode without a flash. Preferably, the radiograph is on a single illuminated X-ray light box in a darkened room. This technique is suitable for plain radiographs, CT, MRI and image intensifier films from theatre.

Correspondence to: Dr D T Loveday, Orthopaedic SHO, Department of Orthopaedics, Arrowse Park Hospital, Wirral CH49 5PE, UK. E-mail: davidloveday@hotmail.com

e-Letters – new additions

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Since the November issue of the Annals the follow letters have been published on our website
www.rceng.ac.uk/services/publications/letters/:

Significance of routine digital rectal examination in adults presenting with abdominal pain - 3 responses