Brachial plexus palsy secondary to birth injuries

Sir,

I read with interest the article by Kirkos et al in the February 2005 issue entitled ‘Brachial plexus palsy secondary to birth injuries: long-term results of anterior release and tendon transfers around the shoulder’. The authors comment that five of the ten patients developed osteoarthritis of the shoulder. Figure 2, from the paper, does not demonstrate this clearly. Would the authors be able to explain how they made this diagnosis, because this is the first reference to the development of osteoarthritis in this group of patients. Prior to this, it was believed that the shoulder did not develop osteoarthritis after obstetric brachial plexus palsy.

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Author’s reply:

Sir,

We thank Mr Williams for his interest in our paper. We agree that osteoarthritis of the shoulder in Erb’s palsy is extremely rare. To the best of our knowledge, there is only a single reference in the literature.1 This is why we use the term ‘degenerative changes’ in our paper. As we mentioned, a gradual decrease of both active and passive movements of the shoulder joint was noticed throughout the decades of follow-up and was attributed to shrinking of the surrounding soft-tissues, deformity and degenerative changes affecting the humeral head. Narrowing of the joint space, sclerosis and degenerative changes of the humeral head (which in our opinion we have shown in Fig. 2c of our paper) are signs of osteoarthritis. Therefore, we believe that our stated clinical and radiological findings permit us to use the term osteoarthritis.

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The care of pin sites with external fixation

Sir,

We read this paper with interest.1 It compares the British consensus method with the Russian method of pin site care. In our unit, we compared pin site infection data collected retrospectively for the British consensus method (group A) and prospectively for a modified version of the Russian method (group B). We also emphasised total pin site care from insertion (no touch technique, pulse drilling etc) to post-operative management (clean weekly with alcoholic chlorhexidine and keep covered). Our modification was to use plastic clips and Allevyn foam squares (Smith & Nephew Healthcare, Hull, United Kingdom) in place of rubber stoppers and alcohol-soaked gauze.

16 All 16 patients in the British consensus group A had a pin site infection requiring oral antibiotics, compared with only 23 of 44 in the Russian method group B (chi-squared test, p = 0.001).

In group A, 10 of 16 patients required hospitalisation for intravenous antibiotics, pin site abscess drainage, or wire changes, while in group B, significantly fewer patients, only 3 of 44, required hospitalisation (p < 0.001).

Our results were similar to those of Davies et al.1 This suggests that the method of total pin site care (no touch technique, pulse drilling with irrigation, weekly cleaning with alcoholic chlorhexidine and keeping covered) is paramount in reducing pin site infection, rather than simply the materials used. In our opinion, plastic clips and Allevyn foam squares are easier to use (and a forgotten clip can always be applied after the wire has been attached and tensioned).

Since the instigation of the Russian method of total pin site care in our unit, there has been a dramatic reduction in infections requiring inpatient hospital care, from 63% to 7%. It would be interesting to see the view ethics committees take on randomised, controlled trials in this field, given the vast difference in serious infections recorded for the two methods.

Meanwhile, the Ilizarov method is no longer synonymous with inevitable serious pin site infection.

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