

CLINICAL TIPS

To all readers of our Journal

We are keen to continue an active correspondence section in our Journal. Please give us your input by writing a paragraph on:

- what method you use to make sure you operate on the right limb
- in how much detail you handle informed consent
- technique tips: how I do it
- any striking information learned from an overseas visit

Send your contributions to the Editor-in-Chief:

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Informed consent

My approach to consent is individualised to the specific patient and the planned procedure. I do not believe in long lists or exhaustive documentation as at the end of the day you rely on your relationship with the patient and trust. I explain the procedure in terms the patient understands, taking their level of education and language skills into account. In private practice, I see the patient the week before the elective admission to discuss the procedure and risks again. The financial aspects are discussed and they are given a printed quote at the time of booking. In state practice, the procedure is discussed on booking and day of admission.

I explain that there is a multitude of risks starting with the car journey to the hospital and that I cannot list all. I explain that the major three complications in spine surgery seldom occur. I discuss these in particular, viz. neurological injury (1:300 mild to severe), infection (0.8%) and non-union (5%). I also explain that although they are few and far between if they occur their incidence is 100%. At the end I make the comparison to a flight where they trust the pilot to do his best and possibly have to make intra-operative decisions on their behalf.

I then ask them if they have any questions. Sometimes this is short and people want minimal explanation but others take far longer.

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Consent is usually taken by the registrar-in-training for acute/emergency cases and elective cases, and occasionally by an intern for acute cases, supervised by a registrar.

The doctor obtaining consent explains the nature, risks and possible consequences of the surgical procedure to the patient or person legally competent to give the consent.

In our environment an interpreter is often used to explain the nature of the procedure. A checklist appears on the consent form for the following information.

- Proposed procedure
- Expected benefits
- Risks and side effects of the procedure
- Possible alternative methods of treatment, risks and side effects
- Probable results if proposed treatment is not administered

The types of anaesthetics used are explained and the consent to use blood or blood products is also obtained. Models or diagrams are used to describe the procedure to the patient or parent.

The patient or parent is invited to ask any relevant questions and simple explanations are provided. Two witnesses sign the consent. In the case of emergency consent this may be obtained by telephone or fax if it is not possible to make contact with the parent or person legally competent to give such consent.

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In my clinical practice a solid doctor/patient relationship is imperative. After taking the patient's history, examination as well as appropriate special investigations, various treatment options are discussed. Informed consent does not only apply to surgery but also to conservative treatment. If surgery is necessary, the procedure is explained as well as the expected result. It is of utmost importance that the doctor's expectations equal that of the patient's. The expected period of hospitalisation as well as the period of immobilisation, for instance in a sling, brace or plaster, are discussed as well as the expected time for recovery. Complications are discussed, appropriate for the specific procedure. For instance, with arthroscopic procedures the use of a tourniquet and prophylaxis for deep venous thrombosis and infection are discussed in broad laymen's terms.

I do not have a specific "indemnity" form that the patient needs to complete but I do make a note in my clinical records that I have discussed the above with the patient.

Every so often one gets the impression that the patient is unsure, does not understand the procedure or is afraid. If I sense any of these, a further appointment is scheduled, free of charge, to again discuss the procedure. The patient is given the opportunity to ask questions regarding the planned course of treatment; very often these questions are only asked at the second appointment after the patient has had time to digest the information that was given at the first appointment.

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Radial head fractures and the swivel head radial prosthesis

Radial head fractures as a result of an indirect injury such as a fall on the outstretched hand is a serious injury to the whole of the fore-arm (i.e. interosseous ligament), as well as the wrist and distal radio-ulnar joints (i.e. Essex-Lopresti injury).

These injuries are more common than previously realised and often go unrecognised.

Late complications pose very difficult clinical management. These include proximal migration of the radius resulting in subluxation of the distal radio-ulnar joint and thus an ulnar positive position. This can have a secondary effect on the TFCC ligament and cause abutment on the ulnar carpal bones.

It is therefore imperative to exclude Essex-Lopresti injuries when dealing with radial head fractures. The radial head must be retained at all cost in these cases.

If the head can be reconstructed this needs to be done as soon as possible. However if the head is comminuted a replacement is indicated with a fixed, straight stem prosthesis.

Unfortunately one sees neglected radial head fractures or failed reconstructed heads which need to be replaced. Invariably soft tissue changes take place which influence the normal functional alignment of the radial head on the capitellum. If a fixed stem prosthesis is used in these cases, mal-alignment is often seen, and even during surgery, when testing flexion-extension and pronation-supination, instability is a real problem.

In order to address this difficult and unsatisfactory problem, a swivel radial head prosthesis has been developed which accommodates the mal-alignment during elbow movements.

The surgical procedure is similar to the fixed head prosthesis. The added advantage of using the swivel head prosthesis lies in the head "following" the capitellum and therefore it adjusts to the relative position of the capitellum, reducing the chances of radial head subluxation or dislocation.

The clinical results with this "mobile" radial head prosthesis warrant the use of the swivel head when biomechanical mal-alignment of the radial head causes instability.

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