

the phrase “standard of care” in the following passage:

While closed reduction with percutaneous pinning and immobilization may have been previously recommended for definitive treatment, better results have been achieved with open reduction, ligament repair and internal fixation, which is now the current standard of care.

This passage from my review was taken from: Grabow RJ, Catalano L III. Carpal dislocations. *Hand Clin* 2006;22:485–500. The referenced quote read:

This [closed reduction and percutaneous pinning combined with immobilization] was previously the recommended treatment; however, recent literature has shown a high rate of recurrent instability, carpal incongruity, and arthritis. For most injuries, better results have been achieved with open reduction, ligament repair, and internal fixation than with closed methods, and *open reduction is now the standard of care*. [Emphasis mine]

I sincerely appreciate Dr. Freshwater’s comments about inflammatory comments in this (overly) litigious society, but it does not change the fact that certain treatment standards do exist and have already

been published in peer-reviewed journals. According to the literature, open reduction and fixation of acute lunate and perilunate dislocations *is* the current standard of care. All of the articles reviewed unanimously recommended open reduction and internal fixation for treating lunate and perilunate dislocations. The scapholunate articulation cannot be reduced closed because of the paradox of Mayfield and Johnson. Accurate carpal alignment needs to be confirmed; this can only be done under direct visualization. According to Weil, Slade, and Trumble, a strong scapholunate interosseous ligament repair is the key to a successful long-term result; obviously, this cannot be performed without an open exposure. Treating these injuries with closed reduction, percutaneous fixation, and immobilization leads to suboptimal results compared with that of open treatment and, according to the literature reviewed, cannot be recommended.

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Nonsurgical Treatment of Fifth Metacarpal Neck Fractures

To the Editor:

I have with great interest read the article by Dr. Hofmeister et al. on the topic of nonsurgical treatment of fifth metacarpal neck fractures (*J Hand Surg* 2008;33A:1362–1368).

Though the aim of the study was to prospectively compare 2 methods of cast immobilization for the management of this injury, there was no mention made of the potential benefit of “buddy” taping and immediate active movement, which can achieve good joint mobility without the cost of lost mobility and possibly lost income during the casting period. As a recent article on this topic¹ was published prior to submission of the article by Hofmeister et al.,² I would be interested in the authors’ reason for this omission and to learn how the results of either of their immobilized groups compared with the results of this mobilized group, particularly as cast avoidance would be expected to be more economical both for the individual and for the health care provider.

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1. van Aaken J, Kämpfen S, Berli M, Fritschy D, Della Santa D, Fusetti C. Outcome of boxer’s fractures treated by a soft wrap and buddy taping: a prospective study. *Hand* 2007;2:212–217.
2. Hofmeister EP, Kim J, Shin AY. Comparison of 2 methods of immobilization of fifth metacarpal neck fractures: a prospective randomized study. *J Hand Surg* 2008;33A:1362–1368.

In Reply:

We appreciate the comments of Mr. Povlsen and his interest in our article. Prior to the final editing of the manuscript, a thorough review of the publications related to our manuscript was performed using 2 online search engines (Ovid and PubMed) that search the U.S. National Library of Medicine (MEDLINE)

databases. Unfortunately, at that time the journal *Hand* was not indexed by MEDLINE. As such, articles in the journal *Hand* could not be retrieved by an electronic search.

Despite this, we have reviewed the article by van Aaken et al.¹ This study is essentially a case series of 25 patients who were followed in a prospective manner after having a soft wrap and buddy taping of the fourth and fifth digits. The authors make no comparison with any other type of treatment, and there is no randomization. Despite no randomization, they compare their cost of treatment and that of operative treatment with K-wires based on a Swiss tax point system and conclude that the wrap and buddy taping is less expensive. The authors concede that more data is needed to determine the effect of angulation and shortening on outcome. Additionally, without a comparison group, whether it be a casting group or an operated group, definitive conclusions cannot be made as to which method of treatment is superior.

A comparison of the results of our study to the van Aaken et al. study would be difficult as the van Aaken et al. study measured the angulation of the fifth metacarpal on an oblique radiograph, whereas ours were measured on a lateral radiograph. Additionally, it should be pointed out that our study

involved active-duty military personnel whose income is not compromised by casting treatment.

The purpose of our study was to compare 2 casting methods for fifth metacarpal neck fractures to determine which was superior in maintaining reduction, which was simpler to apply, and if there were any joint issues after being immobilized in extension. We believe we have answered these questions in a prospective randomized study. Unfortunately, neither we nor Mr. Povlsen can address the question of whether cast avoidance would be more economical without a prospective, randomized, long-term follow-up study of complications of displaced healing.

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Reconstruction of Circulation in the Fingertip Without Vein Repair in Zone I Replantation: Reconstruction or Reduction?

To the Editor:

We read the article by Zhang et al. on "Reconstruction of Circulation in the Fingertip Without Vein Repair in Zone I Replantation" with some interest. We can only commend their results on a 96% overall success rate and cannot on this basis critique their technique. However, the physiological explanation upon which their technique is predicated is fundamentally flawed and overcomplicated. The authors talk about reconstructing an internal circulation within zone I by repairing both digital arteries and then ligating the larger artery, located dorsally, at the L point and either ligating or transecting its medial and volar branches distal to the L point. Thus, they argue that this vessel is now transformed into a vein and able to complete an efficient vascular loop, remedying the perennial problem of venous congestion. Unfortunately, we believe this to be untrue, and

ligating the larger of the two arteries serves to merely limit the inflow into the fingertip significantly, thereby effectively reducing the workload on the venous side of the circuit. This is based on the fact that the metabolic demands of the fingertip are more than adequately met by the two proper digital arteries and that survival is more than feasible on the supply of one. Although the explanation provided by Zhang et al. is a more attractive one, we strongly believe in "calling a spade a spade. We therefore look forward to the authors' comments.

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