

In Reply:

Administration of vitamin C for preventing complex regional pain syndrome (CRPS) after a distal radius fracture (DRF) is an intriguing possibility. CRPS is a devastating syndrome that has no clear etiology other than the hypothesis of sympathetic overtone that can cause chronic pain after a trauma. Owing to the absence of a case definition and an identifiable unified etiology, the diagnosis of CRPS is based on subjective criteria defined by the International Association for the Study of Pain (IASP). Therefore, recent interest in finding a magic potion to reduce the incidence of CRPS after a DRF in the form of vitamin C is an intriguing option.

However, as the authors aptly noted, the finding of salutary effect of vitamin C is based on two randomized controlled trials (RCTs) conducted at a single center.¹ The application of any experimental finding must consider that spurious result is not a concern. Because vitamin C is inexpensive and potentially harmless unless taken in large doses, the presence of any beneficial effect to prevent CRPS makes its use appropriate. Its usage is largely adopted after the recommendation of the American Association of Orthopedic Surgeons for its preventative effect.² A recent RCT by Ekrol et al represents a unique contribution to refute the affirmative effect of vitamin C on CRPS rate reduction, however.³ In fact, the study found no beneficial effect in functional outcomes or fracture healing compared with placebo.

Is the vitamin C situation a unique event that was refuted by subsequent studies? Carpal tunnel syndrome was associated with deficiency of vitamin B6. Several publications from a single center study with selected patients gave hope that ingestion of high doses of vitamin B6 could treat carpal tunnel syndrome, presumably because of vitamin B6 deficiency in this disease.⁴ Subsequent studies found no such relationship between vitamin B6 and carpal tunnel syndrome, however.⁵ In fact, large doses of vitamin B6 can cause harmful effects including sensory

and motor neuropathy. Therefore, the message of the vitamin B6 saga is an interesting discussion for two different issues. The first issue is the unknown etiology of a syndrome (CRPS) that does not have a firm diagnostic criteria and established pathophysiology. The second issue relates to a single-center study that appears to advocate a rather unobtrusive treatment of a complex disease that may be too simplistic in its concept. Replication of this study by applying a clinical trial refuted this association. Therefore, the essence of this discussion is that vitamin C may not have scientific evidence to prevent CRPS associated with DRF treatment, although giving this simple remedy to patients may make the surgeons and the patients feel better that they are doing something to avoid this devastating complication. By including this latest study in the pooling of the data, the effect of vitamin C in reducing CRPS incidence may be less convincing.

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Letter Regarding “Oblique Triangular Neurovascular Osteocutaneous Flap for Hook Nail Deformity Correction”

To the Editor:

We read with interest and commend the authors¹ on their endeavor to solve a common yet difficult problem. The authors present a well-written article with supporting photographs and diagrams to facilitate the adoption of

their new technique. Nevertheless, careful examination of these supplementary items reveal points that raise concern regarding this technique and its potential use.

Our first concern regards the position of the K-wire to support the osteocutaneous flap. Both the radiographs

and diagrams show that the K-wire is sited within the flexor digitorum profundus (FDP) tendon. This position has increased risks of abrasion, rupture, or infection, and we would ask why the K-wire is not placed within bone instead?

The authors also mention releasing part of the insertion of the FDP. This would increase the risk of rupture to the FDP tendon.

In the preoperative photograph the nail is not trimmed, yet in the postoperative photograph it is. This suggests that the patient continues to have a hook nail deformity after the flap. It would be judged that there is no improvement in the position of the full edge of the sterile matrix. This raises questions regarding its efficacy given its technical difficulty and potential complications.

One more minor point, Figure 2 shows an FDP insertion point far too proximal. This makes it appear

that the amount of bone available to osteotomize and move is much larger. This could be misleading.

Finally, the authors present their technique in one patient. We believe that a series of such cases would perhaps add weight to the efficacy and reliability of this technique with regards to outcomes and potential complications.

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Reply to “Acute Hand Infections”

To the Editor:

The review article on acute infections¹ in the August 2014 issue of the *Journal of Hand Surgery* was of considerable interest to me because I have authored numerous articles as well as the chapter on infections in *Green's Operative Hand Surgery* for the first 4 or so editions. I was pleased to see the acknowledgment that surgical irrigation of the tendon sheath through windows was a successful technique to treat pyogenic flexor tenosynovitis.

I noted, however, that credit for the description of the technique did not include multiple publications that I published on the topic, beginning with one in the *Journal of Hand Surgery*.² Having been directly involved in being a journal editor for 22 years, I am keenly aware that there is a tendency to overlook older articles even if they are particularly germane to the topic being discussed. It is unfortunate, but many extremely valuable reports in the literature exist before the start of one's residency.

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In Reply:

Dr. Neviasser's comment is dead on. His article¹ is a classic and should be read by any surgeon who treats hand infections.

Over the years, I have compiled a series of classic articles on nearly 60 topics relevant to hand surgery. These articles form the basis of a weekly journal club in which our residents and fellows discuss the articles and faculty provides insight as to relevance and significance. Needless to say, Dr. Neviasser's article is included in the group covering hand infections.

On behalf of my coauthors, Drs. Osterman and Draeger, we apologize for this oversight.

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