LETTER TO THE EDITOR

Re: ‘Longitudinal instability of the forearm: anatomy, biomechanics, and treatment considerations’

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Sir,

We read with interest the recent review article by Sabo and Watts on ‘Longitudinal instability of the forearm: anatomy, biomechanics, and treatment considerations’ [1]. We commend the authors on their review, but would like to discuss some issues arising from this work. First, we would suggest that the degree of radial shortening indicative of an Essex-Lopresti lesion is debated throughout the literature, with values ranging from 2 mm to 1 cm [2,3]. Interestingly, the authors do not appear to discuss the commonly used intraoperative assessment of Essex-Lopresti lesions using the push–pull test (axial traction and compression of the hand and wrist looking for a more than 3 mm change in the distance between the radial neck and the capitellum) after radial head excision as a test for the diagnosis of interosseous ligament injury and forearm instability [4].

We would also like to highlight some notable inaccuracies regarding the authors’ discussion of our paper [5]. Our study documented that 60 of 237 patients had wrist and forearm pain 6 weeks after an ipsilateral radial head fracture, but only 22 (9%) had radial shortening of more than 2 mm (not 30% as the authors suggest) [5]. Furthermore, only one patient underwent operative intervention for a suspected true Essex-Lopresti lesion that was confirmed intraoperatively, which we state clearly in our paper. This would indicate a true incidence of less than 1%, consistent with the other available literature [6,7]. Radiographic follow-up was collected for all patients until discharge.

Unlike the suggestion of Sabo and Watts, the primary findings of our paper were not to challenge the incidence of longitudinal instability or to determine the degree of shortening suggestive of an Essex-Lopresti lesion as we state. We feel that our study provides useful evidence that approximately 10% of patients with a fracture of the radial head may present with associated wrist pain and a degree of radial shortening, however, over 90% are not complete or true Essex-Lopresti lesions that do well with conservative management. Our paper adds to previous work examining the less complex fractures of the proximal radius and the potential association with a spectrum of Essex-Lopresti lesions [8,9], and we strongly disagree that describing these injuries as a spectrum is misleading. Furthermore, the concept of a spectrum of injury increases the index of suspicion for these lesions, as Sabo and Watts suggest themselves, particularly when associated with increasing fracture complexity and higher energy injuries [9,10].

References

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